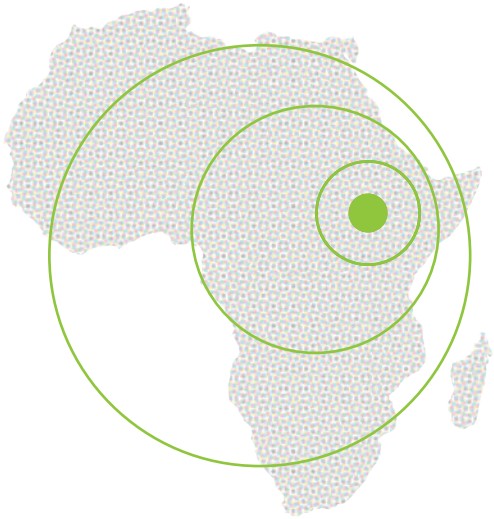

Toolkit on regulatory approaches to noncommunicable diseases: healthy diets and physical activity

(East African edition)

IDLO
Creating a Culture of Justice
International Development Law Organization

Contents

Acknowledgements

This publication was produced by the International Development Law Organization (IDLO) under the Global Regulatory and Fiscal Capacity Building Programme (Global RECAP) 2019–2021. Global RECAP is a collaborative project between IDLO and the World Health Organization (WHO), supported by the Swiss Agency for Development and Cooperation (SDC) and the OPEC Fund for International Development (OFID) and in coordination with the International Development Research Centre (IDRC).

The publication draws on background reviews undertaken by WHO, involving desktop research of the legal and policy frameworks for Kenya, Uganda and the United Republic of Tanzania that are relevant to the governance of healthy diets and physical activity. The lead author was Maurice Oduor, Advocate of the High Court of Kenya and Lecturer, Moi University School of Law. Valuable comments on the draft manuscript were provided by two external reviewers: Ebenezer Durojaye, Professor of Law and Head of the Socioeconomic Rights Project at the Dullah Omar Institute, University of the Western Cape; and Professor Leslie London, Head of the Division of Public Health Medicine, School of Public Health and Family Medicine, University of Cape Town, South Africa.

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Thanks are also due to the IDLO and WHO staff who reviewed the draft.

Technical editing was provided by Hilary Cadman, Cadman Editing Services, Australia.

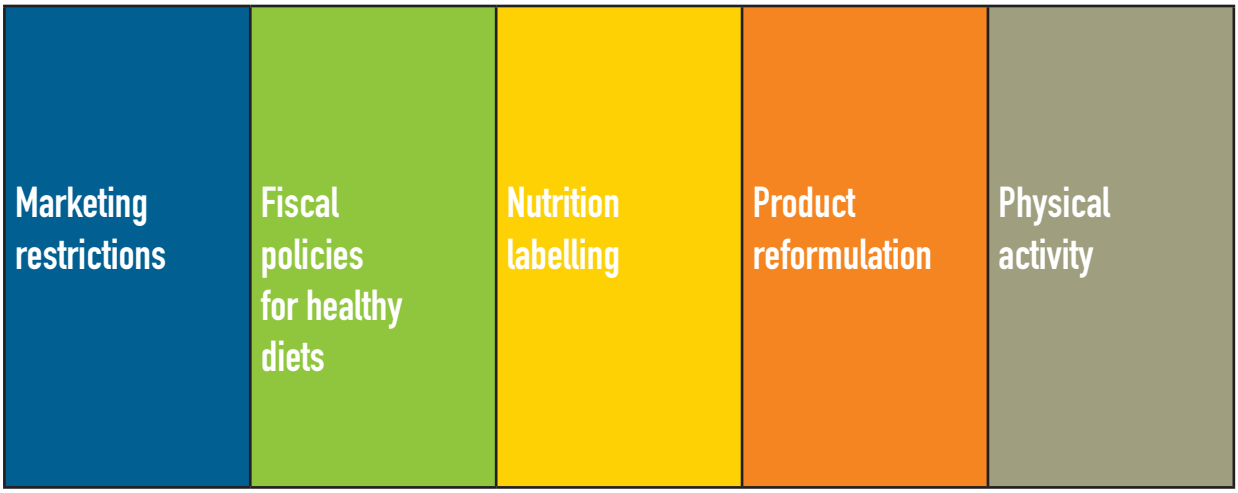
Preface

The rule of law is vital to the response to noncommunicable diseases (NCDs). Well-conceived legal frameworks can lead to healthier lives by ensuring that consumers are fully informed about the foods they eat and have access to quality, healthy products. They can promote healthier diets and more exercise.

The World Health Assembly and the World Health Organization have recognized the role of policy, laws, and regulations, such as regulatory and fiscal reforms, to address NCDs, including through international policy instruments, such as the World Health Organization's (WHO's) Global Action Plan for the Prevention and Control of NCDs 2013–2030, the 2014 Declaration and Framework of Action of the 2nd International Conference on Nutrition and the United Nations General Assembly's 2018 Political Declaration on NCDs. All these documents express the multilateral and national commitment to curb NCDs as a sustainable development priority and suggest that regulatory and fiscal measures are effective means to reach that goal (*2030 Agenda, SDG 3, Target 3.4 "By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and wellbeing"*).

The Global RECAP: Global Regulatory and Fiscal Capacity Building Programme is a collaborative project between the **International Development Law Organization** (IDLO) and the **World Health Organization** (WHO), supported by the **Swiss Agency for Development and Cooperation** (SDC) and the **OPEC Fund for International Development** (OFID) and in coordination with the **International Development Research Centre** (IDRC). Global RECAP aims to strengthen national regulatory and fiscal environments for evidence-informed, coherent and equitable public policies and government interventions to promote healthier diets and physical activity in five countries in East Africa and South Asia. The programme policy focus areas are shown in the figure below. Each country prioritized the areas relevant to their national context.

Regulatory and fiscal policy focus



Although focused on policy responses to NCDs in East Africa, Global RECAP's interdisciplinary approach and foundation in international law offers an approach that can be used in responding to health and development challenges in settings outside East Africa.

This toolkit aims to support the integration of legal approaches in the teaching of public health challenges. It does so by offering public health and legal scholars and students tools and resources that provide guidance on how the law can be used to curb NCDs and, potentially, to address other global health challenges. The toolkit promotes an interdisciplinary approach grounded in international human rights law. It addresses NCDs and regulatory and fiscal responses in three countries in East Africa: Kenya, Uganda and the United Republic of Tanzania.

Foreword

Noncommunicable diseases (NCDs) are on the rise in Africa, in part due to an increase in unhealthy diets and a lack of adequate physical activity. Since 2020, the African region has also struggled to meet the challenges of coronavirus (COVID-19), the impact of which is increased by NCD comorbidity.

All the social and commercial determinants of health and of NCDs exist within legal frameworks that can help or hinder national, regional and international responses designed to promote healthy lives and well-being. Public health professionals in Africa can benefit from an appreciation of these frameworks and of how the enabling legal environment can be restructured to reduce NCD risk factors.

This toolkit is the product of a unique collaboration between legal and public health experts in Kenya, the United Republic of Tanzania and Uganda. Although the geographical focus is on East Africa, the conceptual framework and methodological approach are relevant to all countries in sub-Saharan Africa. The approach described here suggests a path for fostering further multidisciplinary research on and understanding of NCDs and other public health challenges. The toolkit has the potential to influence teaching and learning by creating the right social and legal mindset on NCDs among public health students.

I commend the authors and recommend the publication to members of the Association of Schools of Public Health in Africa.

Dr Philip B. Adongo
President, Association of Schools of Public Health in Africa (ASPHA)
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Foreword

Throughout the world, people are affected by the increase in noncommunicable diseases (NCDs) and associated ill-health, including cardiovascular and chronic respiratory diseases, cancer, diabetes and mental disorders. People with NCDs are often more susceptible to serious illness from infectious diseases such as coronavirus (COVID-19). In East Africa, as in other regions, NCD risk factors include unhealthy diets and a lack of physical activity.

Universities should be leading partners in national responses to global health challenges. Hence, they need to build student capacity and equip their students to respond to NCDs; they also need to acknowledge and support students' families and communities, to prevent and mitigate the impact of NCDs. Thus, universities must ensure that the academic community and the student body are informed and engaged.

As this toolkit demonstrates, the law has a central role to play in promoting healthy diets and physical activity. Universities, and particularly schools of law and public health, have a responsibility to ensure that their staff and graduates have the knowledge and skills to research, teach and advise about NCD law and policy.

This toolkit sets out the relevant national law and polices in three countries, and situates the national response to NCDs in the international and regional legal and policy context. It was developed through a novel joint and multidisciplinary collaboration between academic staff from schools of law and schools of public health in East Africa (Kenya, Uganda and the United Republic of Tanzania) convened to reflect on the role of the law in the response to NCDs in the region. The toolkit is designed to provide academics with practical teaching tools to engender these discussions among students from different disciplines.

One resource, however comprehensive, cannot address the many challenging questions about NCD law and policy. We welcome further research on the role of the law in addressing the social and commercial determinants of health, and the challenges of inequality, injustice and discrimination.

We recommend this toolkit to our academic staff, to students of law and of public health, and to the wider university community.

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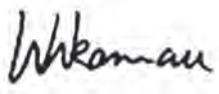

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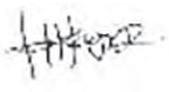

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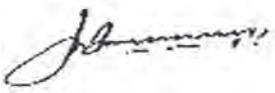

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List of abbreviations

AU	African Union
BMI	body mass index
CEDAW	Convention on the Elimination of all Forms of Discrimination against Women
CRC	Convention on the Rights of the Child
DALY	disability-adjusted life year
EAC	East African Community
FAO	Food and Agriculture Organization of the United Nations
HIV	human immunodeficiency virus
I$	international dollars
ICESCR	International Covenant on Economic, Social and Cultural Rights
ICN2	Second International Conference on Nutrition
IDLO	International Development Law Organization
LMIC	low- and middle-income countries
NAB	non-alcoholic beverage
NCD	noncommunicable disease
NGO	nongovernmental organization
PES	physical education and sports
SDG	Sustainable Development Goal
TFNC	Tanzania Food and Nutrition Centre
UN	United Nations
UNCESCR	United Nations Committee on Economic, Social and Cultural Rights
WHO	World Health Organization

INTRODUCTION TO THIS TOOLKIT

Why law and noncommunicable diseases?

The right to the highest attainable standard of physical and mental health is a human right that is recognized in the Constitution of the World Health Organization (WHO) and in international law. Noncommunicable diseases (NCDs) present a public health issue of grave concern globally, including in low- and middle-income countries (LMICs). In response, the international community has focused on four major risk factors for NCDs: tobacco use, harmful use of alcohol, unhealthy diets and physical inactivity (1).

The Global Action Plan for the Prevention and Control of Noncommunicable Diseases (now current through 2030) (2) (hereafter referred to as the "Global Action Plan on NCDs") contains globally agreed strategies to address the four risk factors. The interventions in these strategies will require the collaborative input of all sectors of the community, and if their implementation is to be successful, it will need to be anchored in legal and governance structures (3). Thus, preventing, managing and responding to NCDs requires solid legal and regulatory frameworks, and accountable and transparent institutions grounded in the rule of law and human rights principles. For example:

- taxation cannot be effected without a mandate exercised under law;
- interventions on healthy diets may require governments to use the law to regulate the types and formulations of foods available in the market; and
- enforcement of agreed measures may require the exercise of a legal mandate bestowed upon a government ministry or agency.

Interventions will sometimes trigger legal disputes, and these must be resolved by courts applying agreed legal standards. Importantly, these interventions are part of the wider obligation on States to protect and promote the right to health. Framing the NCD response as an issue of human rights invites broader discussion of the indivisibility of civil, political and socioeconomic rights, the active agency of those most vulnerable to NCDs, and crucial issues of State and industry accountability (4). The law is both a key component among the many tools that can be deployed for the prevention and control of NCDs, and an often essential part of the implementation of those tools (5).

Background and rationale

There is a well-defined global policy framework on NCDs, yet many countries have not fully implemented all the actions recommended to address the four main risk factors. This toolkit focuses on the global, regional and domestic regulatory frameworks that can be deployed to address the prevalence of unhealthy diets and physical inactivity in three countries in East Africa: Kenya, the United Republic of Tanzania and Uganda. Much progress has been made in the area of tobacco control, where a legal approach has been taken through adoption of a binding treaty (6). Despite the absence of a global compact on alcohol control, countries have shown interest in legislating in that area, both on the domestic and regional fronts.[1]

This toolkit focuses on two risk factors that appear to have attracted scant legal attention: unhealthy diets and lack of physical activity. The aim is to stimulate thinking on the role of law in promoting healthy diets and physical activity as part of the wider response to NCDs in Kenya, Tanzania and Uganda. The toolkit is premised on human rights principles stated in international and regional documents, global NCD policy frameworks and relevant domestic legal instruments. Under the Global Action Plan on NCDs, countries are encouraged to institute measures that will reduce premature

[1] For example, in the case of Kenya, domestic alcohol regulation can be seen through legislative instruments such as the Alcoholic Drinks Control Act, and regional alcohol control efforts can be seen through the adoption of the East African Community (EAC) regional policy on alcohol, drugs and substance use (7).

deaths arising from NCDs, reduce sodium and salt intake, reduce the prevalence of high blood pressure, reduce the prevalence of insufficient physical activity, and completely halt the rise in the incidence of diabetes and obesity. Technical guidelines and recommendations elaborate specific measures to be undertaken in the context of physical activity (8), salt and sugar intake (9, 10), and marketing of foods and non-alcoholic beverages (NABs) to children (11). In addition, domestic policy and legal frameworks (e.g. constitutional protections of the right to life and to health) can be used to reinforce broad human rights and standards specific to commitments related to NCDs (12).

Purpose and scope

This toolkit focuses on regulatory and fiscal measures to avoid or reduce the major NCD risk factors of unhealthy diets and physical inactivity. It does not address the two other major risk factors (tobacco use and the harmful use of alcohol) or secondary strategies for NCD prevention and treatment.[2] As mentioned above, this publication focuses on three countries in East Africa: Kenya, Tanzania and Uganda. With few exceptions, undergraduate training of legal and public health professionals in these countries does not include the law's role in promoting health. This toolkit is a resource that can be used to develop curricula that incorporate regulatory and fiscal measures for the promotion of healthy diets and physical activity. It can also help to strengthen capacity within the areas of law and public health, by supporting the work of legal and public health academia in universities.

The toolkit is intended for academics and students in public health, law and related disciplines. It deals with legal approaches to health; thus, students of law can use it to learn how laws, regulations and legal strategies can be used to promote public health outcomes. However, the text is designed to be accessible to students in disciplines other than law. For example, those studying medicine and public health can use it to understand how law relates to public health, and those studying government and public administration can use it to understand how law can influence public health decisions in the context of NCDs. As a common academic resource, the toolkit may stimulate and strengthen dialogue between different disciplines about NCDs and potentially about other global health challenges.

Methodology

This toolkit presents and analyses the legal and policy frameworks (international, regional and national) that orient governments' decisions on legal and regulatory measures to promote healthy diets and physical activity, and thus to prevent NCDs. It draws on background reviews from WHO involving thorough desktop research on the legal and policy frameworks for Kenya, Tanzania and Uganda relevant to the governance of healthy diets and physical activity. The findings of this desktop research were supplemented through additional research on law and policy relevant to NCD prevention and control.

The publication also involved a participatory, consultative process with academics from schools of law and schools of public health from the three countries involved. In addition to contributing technical and geographical expertise, scholars from different disciplines helped to ensure that the content is suitable for use in legal and other disciplines at various levels. The draft was also shared for review with WHO, and legal and public health academics and expert reviewers. Data on the NCD profiles of each country were derived from national and international sources published by WHO, United Nations (UN) agencies and various ministries or departments from the individual countries.

[2] Secondary strategies aim to stop the progression of disease after its occurrence.

Overview

The toolkit has four parts. The learning objectives, listed at the start of each part, describe what students should be able to do to demonstrate their comprehension after studying the relevant part. Each part also contains exercises or discussion questions intended to stimulate in-depth and practical engagement with the materials it presents:

- Part A explains what NCDs are and the risk factors for these diseases.

- Part B provides the global context, by:
  - § considering the international human rights instruments that influence protection of the right to health, such as human rights frameworks and international trade and investment agreements;
  - § considering the international policy frameworks that address global health policies underpinning action on NCDs (specifically, on healthy diets and physical activity); and noting the issues arising from conflicts of interest and industry challenges in other areas.

- Part C provides the African regional context, by highlighting regional policies on NCDs and the regional human rights framework. Part C also provides examples of strategies from the African region for addressing NCDs using legal and human rights approaches.

- Part D provides the East African subregional context, by:

  - § giving a broad picture of the NCD situation in Kenya, Tanzania and Uganda, referencing data on the four major NCDs, the risk factors and mortality rates; and
  - § reviewing policies and laws in the three countries relevant to healthy diets and physical activity.

Annexes provide additional exercises (Annex 1); data on NCDs for Kenya, Tanzania and Uganda (Annex 2); and further details of relevant legislation in the three countries (Annexes 3–5).

Learning objectives:

- Describe the four major NCDs and their risk factors
- Explain the links between NCDs and gender
- List WHO's general guidelines for healthy diets and physical activity

PART A: INTRODUCTION TO NCDs

CHAPTER 1
WHAT ARE NCDs?

NCDs, also known as chronic diseases, tend to be of long duration and result from a combination of factors: genetic, physiological, behavioural and environmental (1). Since 2000, there has been an increase in the number of deaths arising from NCDs as a proportion of the total number of deaths from all causes (13). Over the same period, NCD-related deaths have increased relative to deaths from communicable causes such as HIV, tuberculosis and malaria. According to WHO, 41 million (75%) of the 55 million global deaths in 2019 were due to NCDs; of these 41 million deaths, 15 million occurred "prematurely" (i.e. in people aged <70 years), and of those 15 million premature deaths, 85% occurred in LMICs (13). Four chronic conditions – cardiovascular diseases, cancers, chronic respiratory diseases and diabetes – account for more than 80% of all premature NCD deaths. In 2019, cardiovascular diseases caused more than 17.9 million deaths globally, followed by cancers (9 million), respiratory diseases (3.9 million) and diabetes (1.6 million) (13). Mental health is also a major contributor to the burden of disease morbidity, but less so in terms of global mortality (14-16).

According to WHO, the NCD burden in the WHO African Region is gradually increasing and is predicted to overtake the burden of mortality and morbidity from communicable diseases by the year 2030 (17). More people from younger age groups will develop NCDs and die from them, even as the management of infectious diseases improves. NCDs are largely preventable; hence, the associated morbidity and mortality can also be prevented.

NCDs, including mental disorders, can interact and amplify each other. WHO has noted that "depression predisposes people to myocardial infarction and diabetes, both of which conversely increase the likelihood of depression", and that "many risk factors such as low socioeconomic status, alcohol use and stress are common to both mental disorders and other noncommunicable diseases" (18). Physical activity can confer some protection from the development of depression in people of all ages. In addition, exercise can be used to manage symptoms and treat people who already have depression (19-21).

CHAPTER 2 RISK FACTORS, GENDER AND HEALTHY LIVING

2.1 NCD risk factors

A risk factor is "an aspect of personal behavior or lifestyle, an environmental exposure, or a hereditary characteristic that is associated with an increase in the occurrence of a particular disease, injury, or other health condition" (22). NCD risk factors can be either *modifiable* or *metabolic*. Modifiable risk factors can be controlled or halted by intervention; they include tobacco use, harmful use of alcohol, unhealthy diet, physical inactivity and air pollution (1). Metabolic risk factors are those associated with the biochemical processes involved in the body's normal functioning (23); they include raised blood pressure, overweight or obesity, hyperglycaemia (high blood glucose levels) and hyperlipidaemia (high levels of fat in the blood) (1). Metabolic risk factors may result from individual genetic predispositions, but they may also result from the habits that increase the chance of developing disease, and in this case can also be prevented and controlled.

NCD-related deaths increased globally in the period 1990–2019 (24). In Africa, as of 2015, the probability of premature deaths from cardiovascular diseases, cancers, diabetes or chronic respiratory diseases stood at 20.9% (the third highest in the world by WHO region) compared with a global average of 18.8% (25). As of 2014, more than 30% of adults in the WHO African Region had raised blood pressure, and data from 2008 showed that 23.1% of adults aged over 25 years had high cholesterol levels. Those figures are now likely to be considerably higher (25).

The reduction and control of these NCD risk factors is at the core of the global regulatory environment on NCDs; thus, the Global Action Plan on NCDs (2) contains set targets and indicators geared towards the promotion of healthy diets and physical activity. WHO Member States have committed to the following by the year 2025: a 25% reduction of premature NCD deaths, a 10% reduction of insufficient physical activity, a 30% reduction of salt/sodium intake, a 25% reduction of raised blood pressure,[1] and a complete halt in the rise of obesity and diabetes.

2.2 NCDs and gender

NCDs and their risk factors affect men and boys differently from women and girls. Throughout the WHO African Region, data show higher rates of raised cholesterol levels and overweight and obesity among women than men (24).[2] Also, the level of physical activity is often higher among men than women.[3] These disparities arise from the manner in which gendered social, cultural, status and power differences interact with genetic and biological differences between the sexes.

In general, men smoke tobacco and drink alcohol more than women, and suffer more from cardiovascular diseases. However, girls and women may have fewer opportunities for physical activity, particularly in urban contexts. Norms that compare physical aggressiveness unfavourably with norms of femininity may open up girls to criticism when they engage in sporting activities that defy cultural stereotypes about the roles of men and women (28). Parents become part of the social reinforcement continuum for gender stereotypes when they disapprove of norm-defying tendencies among their children (29).

NCDs during pregnancy can lead to increased

[1] Raised blood pressure (hypertension) refers to blood pressure above 140/90. The 140 represents the systolic count (systolic blood pressure), which is the pressure in the arteries when the heart beats, and the 90 represents the diastolic count (diastolic blood pressure), which is the pressure in the arteries when the heart rests between beats (26).

[2] Obesity and overweight are related. A person is overweight when their body mass index (BMI) is between 25 and 30, and obese when their BMI is 30 or above (27). In the study cited, male–female difference was considerable, with a prevalence of 24.8% among females and 21.2% among males. This difference was found in all but two countries: Mauritius and Seychelles.

[3] In 2010, 82.7% of men were active compared with 75.6% of women (24).

maternal morbidity (hypertensive pregnancy disorders such as pre-eclampsia and eclampsia, overweight and obesity, and depression) and mortality (30). The financial consequences of living with NCDs may be more profound in women; with less access to resources, women are more likely to forego treatment for NCDs, especially in LMICs (31).

2.3 Recommendations for healthy diets and physical activity

2.3.1 Healthy diets

Nutrition guidelines and recommendations have been developed in response to evidence and data from scientific research. Between 1996 and 2019, WHO developed or updated more than 50 nutrition guidelines or recommendations, including with the UN Food and Agriculture Organization (FAO) (32). In 2019, WHO and FAO guidance noted that there are divergent views on the concepts of sustainable diets and healthy diets, and suggested that "countries should decide on the trade-offs according to health situations and goals" (32). Box 2.1 summarizes WHO recommendations for healthy diets in different publications.

Box 2.1. WHO recommendations for healthy diets

"According to WHO, **healthy diets** protect against malnutrition in all its forms, including non-communicable diseases (NCDs) such as diabetes, heart disease, stroke and cancer. Healthy diets contain a balanced, diverse and appropriate selection of foods eaten over a period of time. In addition, a healthy diet ensures that a person's needs for macronutrients (proteins, fats and carbohydrates, including dietary fibre) and essential micronutrients (vitamins and minerals) are met, specific to their gender, age, physical activity level and physiological state… While the exact make-up of a healthy diet varies depending on individual characteristics, as well as cultural context, locally available foods and dietary customs, the basic principles of what constitutes a healthy diet are the same" (33):

- consumption of at least 400 g (i.e. five portions) of fruits and vegetables per day;
- limiting the intake of free sugar to less than 10% of total energy intake (10);[a]
- limiting the intake of fat to less than 30% of total energy intake;
- a preference for unsaturated rather than saturated fats (34, 35);[b]
- reducing the intake of saturated fats to less than 10% of the total energy intake and *trans* fats to less than 1% (34);
- complete avoidance of industrially produced trans fats (34, 35);[c]
- less than 5 g (equivalent to 1 teaspoon) of salt intake per day for adults (and even less for children) (9); and
- breastfeeding for children (exclusively for the first 6 months and continuously until 2 years and beyond), with the introduction of complementary foods after 6 months (36).

[a] The WHO guidelines define free sugar to include "monosaccharides and disaccharides added to foods and beverages by the manufacturer, cook or consumer, and sugars naturally present in honey, syrups, and fruit juice concentrates".

[b] Unsaturated fats are those found in fish, avocado, nuts, and sunflower, soybean and canola oils. Saturated fats are found in fatty meat, butter, palm and coconut oil, cream, cheese, ghee and lard.

[c] *Trans* fats are found in baked and fried foods, and pre-packaged snacks and foods, such as frozen pizza, pies, cookies, biscuits, wafers, and cooking oils and spreads. Ruminant *trans* fats are found in meat and dairy foods from ruminant animals.

2.3.2 Physical activity

Physical activity refers to any bodily movement produced by skeletal muscles that requires expenditure of energy (37). Regular physical activity can help in the prevention and treatment of cardiovascular diseases, diabetes, and breast and colon cancer. It can also help to prevent hypertension, maintain body weight, and improve mental health, quality of life and well-being. Activities such as walking, cycling, sports, active recreation and play can meet the health needs of the heart, body and mind. Member States can create an environment that promotes physical activity for health benefits, and can use legislation and policy to facilitate programmes that promote physical activity. For example, legislation on urban development can lead to zoning and creation of urban environments that facilitate modes of transport that incorporate active movement (e.g. walking and cycling). School-based programmes can be used to ensure that children meet recommended levels of physical activity. Box 2.2 summarizes WHO recommendations for physical activity (8, 38).

Box 2.2. WHO recommendations for physical activity

- Physical activity should be integrated into daily life across all age groups.
- Infants aged under 1 year should be allowed to be active throughout the day, not be restrained for more than an hour at a time and have zero screen time.
- Children aged 1–4 years should, in a 24-hour period, be active for at least 180 minutes throughout the day, not be restrained for more than 1 hour at any given time, and be allowed sleep time of 10–14 hours (including naps), with regular wake-up times in between.
- Children and adolescents aged 5–17 years should spend an average of 60 minutes per day engaged in moderate to vigorous physical activity and at least 3 days per week on vigorous physical activity and muscle strengthening exercises.
- Adults should spend 150–300 minutes each week doing moderate-intensity physical activity, or at least 75–150 minutes of vigorous aerobic physical activity or an equivalent combination of moderate and vigorous physical activity.

2.4 Exercises

1. Explain the relationship between gender and NCDs.
2. Describe local practices that may have implications for women's access to healthy diets and engagement in physical activity.
3. Explain why men may be more likely than women to suffer from cardiovascular disease.
4. Suggest five actions that could be taken to promote healthy diets and physical activity among women and girls in your country.

Learning objectives:

- Describe the relevant international legal and policy frameworks on healthy diets and physical activity in the context of NCDs, and their role in addressing NCDs
- Describe the nature of human rights obligations in the context of NCDs
- Describe how to apply legal or policy measures that reduce or mitigate risk factors for NCDs associated with unhealthy diets and physical inactivity
- Devise strategies for participating in policy formulation processes for promoting healthy diets and physical activity as a response to NCDs
- Propose specific human rights-based interventions for promoting healthy diets and physical activity as a response to NCDs
- Propose measures to mainstream human rights-based health law and policy development

Part B Global context

CHAPTER 3
INTERNATIONAL LEGAL FRAMEWORKS

3.1 International human rights frameworks

Human rights are those rights that are inherent in a human being – they are not granted by any State (39, 40). They accrue to every human being, regardless of nationality, sex, national or ethnic origin, colour, religion, language or other status (41). Further, all human rights are "universal, indivisible and interdependent and interrelated" (42).

States guarantee human rights through legal instruments that define the contents of rights and provide remedies for violations. These legal instruments, adopted at the international, regional and domestic levels, are unified by the idea of a human rights system that is universal. At the global and regional levels, these legal instruments take the form of treaties. Ratification is always voluntary; however, once a State has ratified a treaty, it is bound to respect the obligations contained in that treaty.

At the international level, the commonality of human rights is exemplified in the key human rights documents: the *Universal Declaration of Human Rights* (UDHR) (43), *the International Covenant on Economic, Social and Cultural Rights* (ICESCR) (44) and the *International Covenant on Civil and Political Rights* (ICCPR) (45). Together, these documents are referred to as the International Bill of Human Rights, implying that they are to be seen as parts of a unified human rights system, and that they reinforce each other. These three instruments enjoy wide acceptance in the international community; they also form the cornerstone of regional and domestic human rights frameworks adopted across the globe. Today, the human rights system has evolved to extend special protections to marginalized and vulnerable people, such as women, children, people with disabilities, and ethnic and racial minorities, with States undertaking specific obligations to protect the rights of individuals belonging to these groups.

These treaty systems do not exist in isolation. All human rights systems are related and share common characteristics, expressed in the concepts of universality and inalienability, indivisibility and interdependence, and equality and non-discrimination. Universality denotes that human rights belong to all human beings, wherever they may be. Human rights are inalienable in that they may not be taken away, except in specific circumstances and according to due process. Some rights cannot be limited under any circumstances; these rights are called "non-derogable rights", and examples include the right to life and the right to freedom from torture, inhuman or degrading treatment. The principles of indivisibility and interdependence denote that all human rights are related to and depend on one another; thus, the attainment of one right depends on the fulfilment of other rights. For example, the right to health is contingent on States fulfilling rights such as the rights to food, adequate standards of living, water and other underlying determinants of health. Indeed, the right to health denotes a whole range of interdependent claims, each working with the others to make a complete whole. Finally, the principles of equality and non-discrimination denote that all human beings are equal in dignity and human rights.

Human rights engender three types of obligations by the State:

- to *respect*, which requires that the State refrains from interfering with or curtailing the enjoyment of a human right;
- to *protect*, which requires that the State protects individuals and groups against human rights violations by non-State actors; and
- to *fulfil*, which requires that the State takes positive action to facilitate the enjoyment of basic human rights.

International treaties do not directly incur private sector obligations; however, there is increasing international scrutiny of the role of States in regulating the private sector to protect human rights, and the related responsibilities of the private sector.

In 2011, the UN Human Rights Council endorsed guiding principles on business and human rights (46). In addition, some States have proposed a binding treaty on business and human rights (47).

Conflicts of rights may arise in the implementation of public health measures to address NCDs (e.g. regarding tobacco control and the issue of second-hand smoke). Some human rights can be limited by law on public health grounds and during states of emergency, subject to strict legal tests (48). Most importantly, the human rights approach stresses the obligations of States to ensure the participation of communities in the development of laws and policies that affect them. In the African context, Ubuntu and related cultural concepts also contribute to the understanding of individual and collective rights and responsibilities (49).

3.1.1 The right to health in the UN human rights framework

Since health was enunciated in 1948 in Article 25 of the Universal Declaration of Human Rights (43), the right to health is now firmly entrenched in the UN human rights framework and in regional human rights systems.

International Covenant on Economic, Social and Cultural Rights

Article 12 of the ICESCR (44) recognizes the right to "the enjoyment of the highest attainable standard of physical and mental health" (see Box 3.1).

Box 3.1

ICESCR ARTICLE 12 – IMPLICATIONS FOR NCDs

Article 12(2)		Examples of applicability to NCDs
The steps to be taken by the States parties to the present Covenant to achieve the full realization of this right shall include those necessary for:	(a) The provision for the reduction of the stillbirth rate and of infant mortality and for the healthy development of the child;	States should regulate the marketing of breast-milk substitutes, and the marketing of foods and beverages to children. States should also promote adequate physical activity among children (50).
	(b) The improvement of all aspects of environmental and industrial hygiene;	"The urban/built environment, in terms of transport infrastructure facilitating walking and cycling, and favourable land-use patterns, as well as working conditions, may further impact on levels of physical activity and sedentary lifestyle. These in turn are associated with overweight, obesity, cancers and other NCDs." (51)
	(c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;	States are obligated to take steps that will reduce or eliminate environmental and industrial hazards to health.
	(d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.	The right to health includes the provision of equal and timely access to basic preventive, curative, rehabilitative NCD health services and health education; regular screening programmes; and appropriate treatment of prevalent diseases, illnesses, injuries and disabilities.

ICESCR: *International Covenant on Economic, Social and Cultural Rights*; NCD: noncommunicable disease.

States' implementation of ICESCR is monitored by the United Nations Committee on Economic, Social and Cultural Rights (UNCESCR). The UNCESCR has interpreted the right to health as an inclusive right that extends not only to timely and appropriate health care but also to the underlying determinants of health (e.g. access to safe and potable water, an adequate supply of safe food and nutrition, and access to health-related education and information). UNCESCR has also stressed the importance of the participation of the population in all health-related decision-making at the community, national and international levels. The right to health contains the following interrelated and essential elements: availability, accessibility, acceptability and quality (the "AAAQ framework"). Following the guidance of General Comment 14 (52), these elements are explored in the context of NCDs in Box 3.2.

Box 3.2

ELEMENTS FOR THE RIGHT TO HEALTH AND IMPLICATIONS FOR NCDs

Element	Examples of implications for NCDs
Availability	Functioning public health and health care facilities, goods and services to address NCDs must be available in sufficient quantity. The precise nature of the facilities, goods and services will vary depending on numerous factors, including the State party's developmental level. They will include, however, the underlying determinants of health, such as safe and potable drinking water.
Accessibility	Facilities, goods and services to address NCDs must be accessible to all without discrimination. Special measures should be instituted for vulnerable or marginalised groups such as women, children, older persons, ethnic minorities, people with disabilities, and those with HIV and AIDS. Facilities should be physically accessible. This has implications for the distribution of facilities and services in less urban settlements with fewer resources. Accessibility also means affordability. NCD-related goods and services, as well as services related to the underlying determinants of health, must be affordable for all. Accessibility also denotes the right to seek, receive and impart information and ideas concerning NCDs, while observing the confidentiality of personal health data.
Acceptability	Facilities, goods and services to address NCDs must respect medical ethics and be culturally appropriate (i.e. respectful of the culture of individuals, minorities, peoples and communities, sensitive to gender and life-cycle requirements), as well as being designed to respect confidentiality and improve the health status of those concerned.
Quality	Health facilities, goods and services to address NCDs must be scientifically and medically appropriate and of good quality. This requires, for example, skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation.

AIDS: acquired immunodeficiency syndrome; HIV: human immunodeficiency virus; NCD: noncommunicable disease.

ICESCR provides for "progressive realization" and acknowledges the constraints due to the limits of available resources. Nevertheless, States have a specific and continuing obligation to move as expeditiously and effectively as possible towards the full realization of the right to health.

ICESCR also imposes on States various obligations that are of immediate effect, referred to as "core obligations". UNCESCR has noted that, in the context of the prevention of NCDs, core obligations include obligations to provide services on a non-discriminatory basis, especially for vulnerable and marginalized groups; to ensure access to the minimum essential food that is nutritionally adequate and safe, to ensure freedom from hunger to everyone; to ensure an adequate supply of safe and potable water; and to adopt and implement a national public health strategy and plan of action that address the health concerns of the whole population, with particular attention to all vulnerable and marginalized groups. UNCESCR has also noted the obligations to provide education and access to information concerning the main health problems in the community, including methods of preventing and controlling them; and to provide appropriate training for health personnel, including education on health and human rights. In addition, UNCESCR has emphasized that it is particularly incumbent on States parties and other actors in a position to assist, to provide international assistance and cooperation (especially economic and technical) to enable developing countries to fulfil their core and related obligations (52, 53).

The right to health in international law includes obligations of both *process* and *result*. UNCESCR noted in General Comment 14 that a State's core obligations include the adoption and implementation of "a national public health strategy and plan of action… devised, and periodically reviewed, on the basis of a participatory and transparent process…" (52). UNCESCR also noted that (52):

> The formulation and implementation of national health strategies and plans of action should respect, inter alia, the principles of non-discrimination and people's participation. In particular, the right of individuals and groups to participate in decision-making processes, which may affect their development, must be an integral component of any policy, programme or strategy developed to discharge governmental obligations under article 12.

Various UN Special Rapporteurs on the right to health have given specific guidance on States' obligations to address diet-related NCDs through a right-to-health framework (see, for example, this 2014 publication (54)). In 2020, Special Rapporteur Dainius Pūras called on States to adopt regulatory measures aimed at tackling NCDs, with a specific focus on food-related measures (e.g. front-of-package labelling), as a way to comply with their obligations under the right to health. The statement recognized States' obligation to ensure "equal access for all to nutritiously safe food as an underlying determinant of health" (55). It reads:

> As adequate food is a human right in itself, States' obligations include ensuring everyone's access to the minimum essential food that is sufficient, nutritionally adequate and safe; this involves food in sufficient quantity and quality to satisfy individuals' dietary needs, with a mix of nutrients for physical and mental growth, development and maintenance.

The statement was endorsed by the Special Rapporteur on the right to food, and the UN Working Group on the issue of human rights and transnational corporations and other business enterprises. Similarly, UN Special Rapporteurs have reported on the right to food in the context of international trade law, nutrition, the agriculture–food–health nexus, agribusiness, globalization, transnational corporations and related issues (56).

Convention on the Rights of the Child

The Convention on the Rights of the Child (CRC) affirms and elucidates the right to health of children, and the responsibilities of States in respecting, protecting and fulfilling those rights, including promoting them through international cooperation (57). It defines a child as any person aged under 18 years, meaning that its protections include children who are adolescents aged 13–17 years. Four fundamental principles inform the CRC: non-discrimination; best interest of the child; the child's right to life, survival and development; and participation (CRC articles 2, 3, 6 and 12, respectively) (57). The "best interest of the child" principle requires that every action or decision involving or affecting the child – "whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies" (57) – must have the best interest of the child as a primary consideration.

Early-life interventions are critical not only for preventing and managing NCDs in childhood, but also because some of the risk factors established in early life may lead to NCDs in adulthood (58). In addition, many NCD-precipitating behaviours are adopted early in the life of a person (59). Thus, it is critical to have an NCD focus in all matters relating to the health of a child.

Decisions on licensing of food industries, marketing of foods and beverages, urban planning and transport should also be assessed on the manner and the extent to which they affect children. Moreover, the child's right to life requires consideration of the quality of life and development of the child. These principles elevate the child's right to health because they require the State to take broad actions in matters affecting a child's health, including those that have a specific focus on NCDs.

States parties to the CRC recognize a child's right to enjoy "the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health". In addition, States parties commit to "strive to ensure that no child is deprived of his or her right of access to such health care services" (art. 24(1)). The CRC also specifies the health goals to be pursued by States (centring on child mortality, health care, disease, maternal health and information), all of which are relevant to the prevention and treatment of NCDs among children (art. 24(2)) (see Box 3.3).

The UN Committee on the Rights of the Child, which monitors the implementation of the CRC, has issued guidance on the right to health in General Comment 15 (60). The comment envisages children's right to health as an inclusive right that extends not only to prevention, health promotion, curative, rehabilitative and palliative services, but also to the right of children to grow and develop to their full potential and live in conditions that enable them to attain the highest attainable standard of health. General Comment 15 clarifies the State's obligation to promote "healthy eating habits" in children; it requires States to "address obesity in children, as it is associated with hypertension, early markers of cardiovascular disease, insulin resistance, psychological effects, a higher likelihood of adult obesity, and premature death". The State should limit exposure of children to foods "that are high in fat, sugar or salt, energy-dense and micronutrient-poor, and drinks containing high levels of caffeine or other potentially harmful substances". In addition, child-focused marketing of these foods should be regulated (61). General Comment 15 emphasizes that the principle of the best interest of the child must be observed in all health-related decisions concerning individual children or children as a group.

Box 3.3

CONVENTION ON THE RIGHTS OF THE CHILD: NCDs AND THE RIGHT TO THE HIGHEST AVAILABLE STANDARD OF HEALTH (article 24)

Convention on the Rights of the Child	Potential application to NCDs (60)
To diminish infant and child mortality (art. 24 para. 2(a))	States should pay particular attention to ensuring full protection and promotion of breastfeeding practices.
To ensure the provision of necessary medical assistance and health care (art. 24 para. 2(b))	The school context provides an important opportunity for health promotion to screen for illness, and increases the accessibility of health services for in-school children. Essential medicines for the treatment of NCDs should include paediatric formulations and should be available, accessible, affordable and of good quality.
To combat disease and malnutrition (art. 24. para. 2(c))	States should adopt measures to ensure access to nutritionally adequate, culturally appropriate and safe food, and to combat malnutrition according to the specific context. States should protect and promote exclusive breastfeeding for infants up to 6 months of age. Breastfeeding should continue alongside appropriate complementary foods, preferably until 2 years of age, where feasible. School feeding should be combined with nutrition and health education to promote children's nutrition and healthy eating habits. Safe and clean drinking water is essential.
To ensure appropriate pre-natal and post-natal care for mothers (art. 24 para. 2(d))	The care that women receive before, during and after their pregnancy has profound implications for the health and development of their children, including the risk of NCDs. For example, maternal obesity and gestational diabetes may increase the risk of childhood cardiovascular disease and diabetes, with potential adverse consequences for health later in life (62).
To provide information, education and support to all segments of society on child health and nutrition, the advantages of breastfeeding, hygiene, environmental sanitation and prevention of accidents (art. 24 para. 2(e))	Information about NCDs should be physically accessible, understandable and appropriate to children's age and educational level. Information on the benefits of healthy eating habits, physical activity, sports and recreation empowers children and enables them to make decisions about healthy living. When children and their parents are educated about health, their capacity to make healthy choices is enhanced.

NCD: noncommunicable disease.

Convention on the Elimination of all Forms of Discrimination against Women

The Convention on the Elimination of all Forms of Discrimination against Women (CEDAW) (63) seeks to eliminate discrimination against women and girls in all spheres of life, including in the area of health. Article 12 of CEDAW requires States parties to "eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning". States parties should also ensure "appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation".

The Committee on the Elimination of Discrimination against Women, which monitors the implementation of CEDAW, also issues general recommendations that serve to clarify the provisions of the convention. In 1999, the Committee issued General Recommendation No. 24 on women and health (64). That recommendation calls on States to implement comprehensive national strategies to promote the health of women throughout their lifespan; such strategies should include interventions aimed at prevention and treatment of diseases affecting women. The Committee noted that "the full realization of women's right to health can be achieved only when States parties fulfil their obligation to respect, protect and promote women's fundamental human right to nutritional well-being throughout their lifespan by means of a food

supply that is safe, nutritious and adapted to local conditions". States parties should also "Place a gender perspective at the centre of all policies and programmes affecting women's health and should involve women in the planning, implementation and monitoring of such policies and programmes and in the provision of health services to women …" These criteria can guide States in developing and assessing gender-sensitive policies and measures for NCDs prevention and control.

3.1.2 The right to health and NCDs

In the context of NCDs, the concept of health as a human right provides:

- a tool to translate political commitment into scaled-up action on NCDs, holding governments accountable;
- a legal and moral normative framework for delivering health services and addressing the underlying determinants of population health, to address NCDs in an equal and non-discriminatory manner (65); and
- a tool for social mobilization – the language of rights can rally civil society, community leaders, media, researchers and government to influence health law and policy-making and implementation (66).

Human rights provide a yardstick against which the State and other actors can measure policy. They aid the State in developing and implementing policies on health, while providing civil society with an entry point for engaging with the State, to encourage the State to deal with resource deficiencies or improve on existing policy. For instance, a State that considers developing a policy on tobacco control will find inspiration in the general health rights framework, but will also find guidance on specific parameters from an existing regime, the WHO Framework Convention on Tobacco Control (6). A case in point is Kenya. Having passed the Tobacco Control Act in 2007, Kenya subsequently benefited from civil society involvement in a review of the implementation of that legislation in 2012, which culminated in recommendations intended to improve implementation (67).

Human rights treaties address the right to health broadly; they do not provide detailed guidance on States' obligations to promote healthy diets and physical activity. For this guidance we must look to technical agencies such as WHO, and the guidance endorsed by intergovernmental organizations such as the World Health Assembly. As this body of authoritative guidance develops, it can be used to assist monitoring mechanisms such as the UN treaty committees and the Universal Periodic Review process, to assess States' compliance with their human rights obligations. National courts may also draw on this guidance as evidence of States' international obligations.

3.1.3 Population approaches and cost–effectiveness

Policies that reduce NCD risk factors at the population level (generally by making it easier for individuals to make appropriate choices) will also be assessed on their cost–effectiveness (68). For instance, through policy intervention it is possible to require that the food industry produces foods with a limited fat, sugar and salt content, or influences children in a positive way through marketing; or that taxes increase the cost of foods and beverages with more fat, sugar and salt. At the same time as such policies are being implemented, the government should, through education, increase people's capacity to make health-promoting choices; for example, in preventing diabetes (69). The effectiveness of population-wide approaches was first demonstrated in Finland in the context of coronary heart disease (see Box 3.4).

Box 3.4

CASE STUDY ON POPULATION-WIDE APPROACHES TO NCDs

Case study in North Karelia, Finland: effectiveness of populaftion-wide approaches (69)

In the 1960s, Finland led the world in deaths from coronary heart disease, especially in the province of North Karelia. The North Karelia project was initiated through a grassroots campaign supported by regional and national authorities – the first true bottom-up, top-down approach to improving community health. Prevention was seen as key, and interventions aimed to reduce risk for the total population by transforming the social and physical environment.

Lifestyle factors, identified as the drivers of coronary heart disease, included smoking, high intakes of salt and saturated fats, low intakes of fruits and vegetables, and physical inactivity. Interventions included health education, support for tobacco cessation, redesign of towns to create opportunities for increased physical activity, introduction of healthy school meals, and compulsory changes in food manufacturing to reduce both saturated fat and salt. Some 30 years later, there was a dramatic improvement in the health of the population, with deaths from all causes reduced by 62% in men aged 35–64 years, including a reduction of 85% in deaths from coronary heart disease.

NCD: noncommunicable disease.

3.2 International trade and investment agreements

The essence of the international trade regime is to facilitate the free movement of goods and services, by implementing three core principles: prohibition of discriminatory regulation, a bar against unnecessary restrictions on trade and protection of intellectual property rights (70). However, concerns abound over the impact of seemingly neutral international trade rules for LMICs – because of their small market power, LMICs tend to be net recipients of goods from more established producers in developed economies (71). Before the liberalization of international trade in recent decades, food markets tended to be served by local production. However, since liberalization, local producers have sought to service the international market, leaving a gap that has been filled by imported foods, allowing transnational corporations to become established in smaller economies. Thus, international trade has brought both benefits and challenges for small economies (72).

The World Trade Organization (WTO) Agreement on Technical Barriers to Trade bars Member States from adopting measures that create unnecessary obstacles to international trade, except to fulfil a legitimate objective (Article 2.2) such as the protection of public health and safety (73, 74). However, bilateral and regional investment treaties do not necessarily include such a public health exception, and may impede State efforts to prevent and control NCDs. For example, national tobacco control measures have been challenged in international tribunals on the grounds of violation of the entitlements under investment treaties, despite the existence of an international treaty – the WHO Framework Convention on Tobacco Control (75). In addition, bilateral investment treaties can be used to limit the manner in which a State regulates NCDs, especially during negotiations (76). A stronger trading partner can insist on clauses that give greater market access to its industry at the expense of a weaker State's power to protect its people against goods that may have a negative effect on the health of its population.

CHAPTER 4
INTERNATIONAL POLICY FRAMEWORKS

4.1 Commitments and guidance on healthy diets and physical activity

Global policy commitments to promote healthy diets and physical activity have been developed to guide countries in framing their own policies for preventing and controlling NCDs. Unlike international treaties, these policy commitments are not binding; nevertheless, they can inform the interpretation of obligations. Thanks to periodic reviews, and monitoring and evaluation, current policies incorporate lessons learned from their continued implementation. Policies (summarized in Table 4.1) have taken the form of political declarations, guidelines or recommendations, crafted to encourage State action towards the realization of set targets and goals.

Table 4.1

GLOBAL POLICY COMMITMENTS TO PROMOTE HEALTHY DIETS AND PHYSICAL ACTIVITY

Year	Organization	Declaration, guidelines or recommendations
2004	WHA	Global Strategy on Diet, Physical Activity and Health (77)
2010	WHA	Set of recommendations on the marketing of foods and NABs to children (11)
2011–2012	UN	Political Declaration of the High-Level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases (78)
2012	WHO	A framework for implementing the set of recommendations on the marketing of foods and NABs to children (79)
2013	WHA	Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020 (2)
2014	UN	Outcome Document of the High-Level Meeting of the General Assembly on the Comprehensive Review and Assessment of the Progress Achieved in the Prevention and Control of Non-communicable Diseases (80)
2015	UN	Transforming our world: the 2030 Agenda for Sustainable Development (81)
2017	WHA	Tackling NCDs: 'best buys' and other recommended interventions for the prevention and control of noncommunicable diseases (82)
2018	UN	Political Declaration of the Third High-Level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases (83)
2018	WHA	Global Action Plan on Physical Activity 2018–2030: more active people for a healthier world (84)
2019	WHA	Follow-up to the Political Declaration of the Third High-Level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases (85)[a]

NAB: non-alcoholic beverage; NCD: noncommunicable disease; UN: United Nations; WHA: World Health Assembly; WHO: World Health Organization.

[a] This resolution extended the Global Action Plan on NCDs to 2030.

4.2 Transforming our world: the 2030 Agenda for Sustainable Development (2015)

The 2030 Agenda for Sustainable Development (81), which was adopted as a resolution of the UN General Assembly, contains 17 developmental goals – referred to as Sustainable Development Goals (SDGs) – that are intended to provide a blueprint for peace and prosperity across the globe. The 2030 Agenda is unequivocally anchored in human rights (81). Under SDG3, "Good health and well-being", States have committed to "Ensure healthy lives and promote well-being for all at all ages". The NCD target for States is that, by 2030, they shall "reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being" (Target 3.4). However, the integrated and indivisible nature of the SDGs mean that they all have implications for health and hence provide overarching principles that frame responses to NCDs (see Fig. 4.1) (86). For instance, SDG2, "Zero hunger", with its focus on malnutrition in all its forms, is closely interlinked with SDG3 in fostering Member States' commitments to promoting healthy diets and ensuring access to safe and healthy food for all. Similarly, SDG16, "Peace and justice", calls on Member States to strengthen their legal and governance framework as enablers to achieve other goals, including fair, equitable and effective public health services. In 2016, WHO updated the Global Strategy for Women's, Children's and Adolescents' Health to reflect the 2030 Agenda for Sustainable Development (87, 88).

Figure 4.1

SDGs AND HEALTH

SDG: Sustainable Development Goal.
Source: WHO (2021) (89).

4.3 Resolutions of the UN General Assembly on the prevention and control of NCDs

The UN General Assembly has debated NCDs on three occasions: in 2011, in 2014 and in 2018. This section describes the declarations resulting from these debates.

4.3.1 Political Declaration of the High-Level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases (2011)

This political declaration (78) contains commitments by heads of States and governments to address the prevention and control of NCDs worldwide. It has a particular focus on developmental and other challenges, and social and economic impacts, particularly for developing countries. This declaration followed the First Ministerial Conference on Healthy Lifestyles and Noncommunicable Disease Control in Moscow, Russian Federation, in 2011 (90, 91).

Two commitments are relevant in the context of healthy diets and physical activity. The first is the commitment to implement relevant international agreements and strategies, education, and legislative, regulatory and fiscal measures. Specific actions to be taken to fulfil this commitment include developing, strengthening and implementing public policies that create health-promoting environments and promote healthy choices and health education; implementing the Global Strategy on Diet, Physical Activity and Health (77); and implementing WHO's recommendations on the marketing of foods and NABs to children (11) (discussed below). Second is the commitment to strengthen the contribution of the private sector to the prevention and control of NCDs, through actions such as calling on the private sector to implement WHO's recommendations on the marketing of foods and NABs to children (11), and encouraging:

- product reformulation to provide healthier options;
- product labelling;
- the private sector to promote and create an environment for healthy behaviours among workers; and
- the production of foods with reduced salt content.

4.3.2 Outcome Document of the High-Level Meeting of the General Assembly on the Comprehensive Review and Assessment of the Progress Achieved in the Prevention and Control of Non-communicable Diseases (2014)

The 2014 outcome document (80) reaffirmed Member States' commitments to address NCDs (e.g. through implementation of relevant international agreements, legislation, and regulatory and fiscal measures) and to continue to strengthen international cooperation (e.g. through the exchange of best practices in the areas of legislation and regulation).

4.3.3 Political Declaration of the Third High-Level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases (2018)

In this political declaration (83), Member States reaffirmed their commitment to accelerate the implementation of the measures they had committed to in the 2011 political declaration (78) and the 2014 outcome document (80). In line with the 2030 Agenda for Sustainable Development, Member States committed themselves to "reduce by one third premature mortality from non-communicable diseases by 2030 through prevention and treatment and promote mental health and well-being, by addressing their risk factors and the determinants of health" (83). Member States committed to not only scale up implementation of the commitments they made in 2011 and 2014, but also to "implement, according to own-country-led prioritization, a set of cost-effective, affordable and evidence-based interventions and good practices, including those recommended by the World Health Organization, for the prevention and control of non-communicable diseases" (83). Thus, the 2018 political declaration tied commitments made at UN level with complementary commitments made

at WHO level. In particular, Member States bound themselves to implement commitments they made in 2011 and 2014, to reduce unhealthy diets and physical inactivity while taking into account WHO-recommended interventions. For the purposes of this document, the relevant commitments are the recommendations set out in the Global Action Plan on NCDs (2), the Mental Health Action Plan 2013–2020 (18), the Global Strategy and Action Plan on Ageing and Health (92), the Global Action Plan on Physical Activity 2018–2030 (84) and the Global Strategy on Diet, Physical Activity and Health (77).

4.4 Resolutions of the World Health Assembly on NCDs and related WHO guidance

4.4.1 Global Strategy on Diet, Physical Activity and Health (2004)

The Global Strategy on Diet, Physical Activity and Health (77) is a general strategy document adopted by the World Health Assembly. The aim is to assist Member States to develop policies that promote and protect health through healthy diets and physical activity, to reduce deaths and burden of disease. The main objectives of this strategy are to:

- use public health actions to reduce risk factors for chronic diseases that stem from unhealthy diets and physical inactivity;
- increase awareness and understanding of the influences of diet and physical activity on health, and the positive impact of preventive interventions;
- develop, strengthen and implement global, regional and national policies and action plans to improve diets and increase physical activity that are sustainable and comprehensive and that actively engage all sectors; and
- monitor science and promote research on diet and physical activity.

The strategy also references the 1981 International Code on Marketing of Breast-milk Substitutes (93).

Key recommendations of this global strategy are reflected in the 2011 political declaration (78). They can be deployed to assist countries to develop integrated action plans that cover three levels: the host (i.e. the individual), the agent (e.g. the food and drink consumed) and the environment (e.g. changes in national policies and legislation, and the creation of an enabling environment for healthy diets and physical activity) (94).

4.4.2 Set of recommendations on the marketing of foods and NABs to children (2010)

There is robust evidence linking marketing of food and beverage products to children's food and drink preferences (11). Marketing by the food industry is often deliberately child focused; hence, it influences the dietary behaviour of young people and contributes to poor diets, unhealthy weight gain and negative health outcomes (11). Children, particularly infants and children aged under 5 years, are considered "especially vulnerable to marketing practices that promote sugary and salty food and beverage products" (11, 95). In 2010, the World Health Assembly adopted recommendations for Member States on the marketing of food and NABs to children (96). The recommendations called for national and international action to reduce the impact on children of marketing of foods high in saturated fats, *trans*-fatty acids, free sugars or salt. The recommendations specifically support the recommendation from the Global Strategy on Diet, Physical Activity and Health (77) that Member States develop appropriate multisectoral approaches to deal with the marketing of food to children. The recommendations also complement Objective 3 of the Global Action Plan on NCDs (2). They set out the rationale that should inform policies regulating marketing of food and NABs to children, the process that such policies should follow and the important issues to look out for in the course of their evolution.

4.4.3 A framework for implementing the set of recommendations on the marketing of foods and NABs to children (2012)

In 2012, WHO published a framework for implementing the above recommendations (79). The framework:

- defines the concept of "marketing to children", while illustrating industry practices on child-centred marketing and explaining how marketing to children works and who is involved;
- describes a step-by-step process of policy development involving:
  - § situation analysis;
  - § choice of approach (whether comprehensive or stepwise), and the pros and cons of each approach;
  - § determining the children to protect;
  - § determining the communication channels and marketing techniques to target;
  - § determining the foods to include or exclude;
- describes the process of implementation, which involves:
  - § defining who stakeholders are and what roles they have;
  - § determining the implementation options; and
- addresses the need to establish an effective monitoring and evaluation system, while giving practical references on what to monitor and the applicable methods, and proposes a set of indicators that can be easily adopted and adapted.

4.4.4 Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020

The Global Action Plan on NCDs was endorsed by the World Health Assembly in 2013; it includes six objectives and nine voluntary NCD targets (2). The original plan covered the period to 2020; however, in 2019, the World Health Assembly extended it to 2030, to align with the 2030 Agenda for Sustainable Development (85). The plan also sets out a range of policy options that Member States can use to meet the agreed NCD targets. Under Objective 3, Member States seek to "Reduce modifiable risk factors for noncommunicable diseases and underlying social determinants of health" (2).

The policy options were contained in Appendix 3 of the action plan. In 2017, these options were updated (82) to take into account new evidence on cost–effectiveness, new WHO recommendations that show evidence of effective interventions, experience from implementation of the options in the earlier Appendix 3 and commitments made under the 2030 Agenda for Sustainable Development (81). The updated Appendix 3 presents policy options to help Member States to achieve the nine voluntary global targets for NCD prevention and control through the six objectives of the original action plan (2). It contains some overarching actions and 89 interventions divided into three categories, in accordance with a WHO cost–effectiveness analysis:[1]

- the first category comprises 16 interventions referred to as "best buys" (i.e. the most cost-effective measures that Member States can take);
- the second category comprises 20 interventions that have a lower cost–effectiveness ratio; and
- the third category comprises actions that are part of WHO guidance but whose cost–effectiveness has not been measured.

Countries will select their own best buys based on their national context and priorities. The selection process will include taking into account whether the choice represents the highest return on investment in the context of SDG obligations, the priority sectors to be engaged and the practicality of coordinated sectoral commitments.

[1] The cost–effectiveness analysis was based on the average cost, measured in international dollars (I$), that the intervention took to avert a disability-adjusted life year (DALY) in LMICs. A DALY is a measure of time lost due to premature death or to disability inflicted by disease: one DALY equals 1 year of healthy life lost. An intervention is more effective if it takes fewer dollars to reduce a DALY. Interventions in the first category cost less than I$ 100 per DALY (i.e. "best buys"); those in the second category cost more than I$ 100 per DALY.

Healthy diets best buys

In the context of healthy diets, the best buys are the measures considered to be the most cost-effective and feasible for implementation, with an estimated average cost–effectiveness ratio of less than or equal to 100 international dollars (I$) per disability-adjusted life year (DALY) in LMICs.[2] These best buys include measures intended to reduce salt consumption through product reformulation, establishment of supporting environments in public institutions (e.g. hospitals, schools, workplaces and nursing homes) that enable lower sodium consumption, behaviour change communication and mass media campaigns, and front-of-pack labelling (82). Taxation of sugar-sweetened beverages and legislation banning the use of trans fats in the food chain are also recommended as effective interventions, although these interventions have a lower cost–effectiveness ratio.[3] Finally, the third category of recommended impactful interventions includes the promotion of exclusive breastfeeding for the first 6 months of life; the subsidizing of fruits and vegetables to encourage their consumption; replacing *trans* fats and saturated fats with unsaturated fats through reformulation, labelling, and fiscal and agricultural policies; limiting portion and package size to reduce energy intake and the risk of obesity and overweight; implementing nutrition education; implementing nutrition labelling; and mounting mass media campaigns on healthy diets (82).

Physical activity best buys

In the context of physical activity, one best buy is to implement "community wide public education and awareness campaign for physical activity which includes a mass media campaign combined with other community-based education, motivational and environmental programmes aimed at supporting behavioural change of physical activity levels" (82). Providing physical activity counselling and referral as part of routine primary health care services is included as an effective intervention in the second category (with a lower cost–effectiveness ratio). Recommended interventions in the third category include appropriate urban design programmes that encourage active transport, implementing physical activity in school curricula, implementing workplace physical activity programmes, and promoting physical activity through organized sports and clubs and other programmes and events.

4.4.5 Global Action Plan on Physical Activity 2018–2030: more active people for a healthier world (2018)

The action plan on physical activity was adopted by the World Health Assembly in 2018 and provides guidance and a framework of policy actions to increase physical activity at all levels (84). Any form of physical activity can produce health benefits if it is undertaken regularly and for sufficient duration. Examples include walking, cycling, sports, and active forms of recreation such as dance, yoga and tai chi. Critically, the plan acknowledges the potential of physical activity in contributing directly to achieving many SDGs. Thus (84):

> Policy actions on physical activity have multiplicative health, social and economic benefits, and will directly contribute to achieving SDG3 (good health and well-being), as well as other Goals including SDG2 (ending all forms of malnutrition); SDG4 (quality education); SDG5 (gender equality); SDG8 (decent work and economic growth); SDG9 (industry, innovation and infrastructure); SDG10 (reduced inequalities); SDG11 (sustainable cities and communities); SDG12 (responsible production and consumption); SDG13 (climate action); SDG15 (life on land); SDG16 (peace, justice and strong institutions); and SDG17 (partnerships).

[2] Estimate based on WHO CHOICE analysis, available at: https://www.who.int/choice/cost-effectiveness/en/ (accessed on 25 May 2021).

[3] Average cost–effectiveness ratio of ≥I$ 100 per DALY (based on WHO CHOICE analysis).

The targeted outcome is "a 15% reduction in the global prevalence of physical inactivity in adults and in adolescents by 2030" (84). In seeking to achieve this, the plan sets out four strategic objectives – creating active societies, environments, people and systems – that can be achieved through 20 universally applicable policy actions. Guidelines for the type and duration of physical activity have been specified in two documents – *Guidelines on physical activity, sedentary behaviour and sleep for children under 5 years of age* (8) and *WHO guidelines on physical activity and sedentary behaviour* (38).

4.5 International policy guidance on nutrition and food systems

4.5.1 Codex Alimentarius Commission

The Codex Alimentarius Commission was established by FAO and WHO in 1963 and has 188 Member Countries and Member Organizations. In addition, 229 intergovernmental and international nongovernmental organizations (NGOs) are accredited as observers. The Commission develops international food standards, guidelines and codes of practice, and promotes the coordination of all food standards, principally through the Codex Alimentarius (Codex) (97). This includes guidance on nutritional issues, including the development of Nutrient Reference Values (NRVs), product standards for foods for special dietary uses, and other technical information used in the development of labelling standards. "Codex standards support the safe and effective production, preservation, inspection, certification and transport of food along the food chain and its appropriate labelling. Codex standards also support fair practices in the food trade, which in turn supports food security and economic growth." Codex' guidance includes the use of nutrition and health claims (2013), nutrition labelling of packaged foods (2017), and general standards for the labelling of pre-packaged food (2018). "Codex may also consider scientific advice from the WHO Nutrition Guidance Expert Advisory Group (NUGAG). NUGAG's work includes updating the dietary goals for the prevention of obesity and diet-related noncommunicable diseases (NCDs) and the WHO guidelines on sugars and fatty acids" (98). Codex standards are not a substitute for national legislation; however, they may assist in the interpretation of international obligations. For example, Codex is considered by the WTO as the reference for the safety and quality of food traded internationally (99).

4.5.2 Second International Conference on Nutrition, 2014

The Second International Conference on Nutrition (ICN2) was hosted jointly by FAO and WHO in 2014. In the outcome document, the "Rome Declaration on Nutrition", Member States acknowledged that "malnutrition, in all its forms" includes overweight and obesity (100). They also adopted the "Framework for Action", to contribute to ensuring accountability and monitoring progress in global nutrition targets (101). Recommendation 40 of the Framework for Action includes action to address childhood overweight and obesity, and a commitment to regulate the marketing of food and NABs to children in accordance with WHO recommendations.

4.5.3 UN Decade of Action on Nutrition 2016–2025

The UN Decade of Action on Nutrition 2016–2025 (the Nutrition Decade) was launched in July 2016; it aims to accelerate implementation of the ICN2 commitments, achieve the global nutrition and diet-related NCD targets by 2025, and contribute to the realization of the SDGs by 2030. The Work Programme for the Nutrition Decade proposes the establishment of "action networks" – informal coalitions of countries collaborating around one or more of the action areas of the Nutrition Decade, including "through advocating for the establishment of policies and legislation…" (102).

4.5.4 Voluntary Guidelines on Food Systems and Nutrition, 2021

The United Nations Committee on World Food Security (CSF) adopted the *Voluntary guidelines on food systems and nutrition* (VGFSyN) in February 2021 (103). The guidelines aim to support, inter alia, the development of coordinated, multi-sectoral national policies, laws, programmes and investment plans, to enable safe and healthy diets through sustainable food systems. The VGFSyN are grounded in international human rights law and related UN declarations, and "are intended to support governments, including relevant ministries and national, sub-national, and local institutions and authorities, and parliamentarians, to develop processes for the design and imple¬mentation of holistic, multisectoral, science and evidence-based and inclusive public policies…". They contain guiding principles that emphasise, inter alia, accountability, transparency and participation, and gender equality and women's empowerment.

CHAPTER 5 CONFLICTS OF INTEREST AND INDUSTRY CHALLENGES

5.1 Experience from other industries and regions

Corporate actors may seek to influence government policy, including on NCDs. The World Health Assembly has adopted strict guidance for WHO on engagement with non-State actors, including private sector actors and civil society (104). WHO has also developed specific guidance for addressing and managing conflicts in the planning and delivery of nutrition programmes (105).

NCD prevention and control measures often face resistance from industry players (106), as summarized in Box 5.1. The experience from tobacco control is instructive for measures to promote healthy diets and physical activity. Strategies employed by industry to frustrate regulation include bullying, lobbying, litigation, fronting groups to act on their behalf, questioning the evidence of harm and effectiveness of proposed interventions, and proposing self-regulation rather than State regulation (107, 108). As noted above, trade and investment agreements also provide opportunities for industry to challenge NCD prevention and control measures.

In their quest to implement regulations on tobacco, Kenya (109) and Uganda have faced legal challenges from the tobacco industry, including on constitutional grounds. In Kenya, the company British American Tobacco argued against regulations introduced by the Ministry of Health, citing grounds that suggested violations of its right not to be discriminated against, right to property and freedom of association (110). The High Court of Kenya found no violations of the Constitution, stating that the regulations in question were meant to protect public health against a well-known risk. Similarly, in Uganda, the industry challenged tobacco control regulations on constitutional grounds, arguing that the regulations violated the right to property and the right to engage in business, and impugned intellectual property laws (111). The Constitutional Court of Uganda dismissed those objections; for example, stating that the Government of Uganda had a duty to protect the right to life, the right to health and the right to a clean and healthy environment.

Box 5.1

EXAMPLES OF STRATEGIES EMPLOYED BY INDUSTRY TO FRUSTRATE REGULATION

Regulatory or other initiative	Industry tactic	Outcome
In 2017, a tax on SSBs was introduced by the Thai Government to address obesity.	The Thai Beverage Industry Association aimed to stop introduction of the tax by lobbying the legislature and sponsoring newspaper articles that challenged the effectiveness of the tax in reducing childhood obesity (112).	The tax was adopted. The industry's request to participate in the tax implementation plan was denied because of conflict of interest.
Several states in the USA have introduced taxes on soda to reduce consumption and address obesity.	The American Beverage Association spent US$ 7 million to fund an initiative to amend the laws used by cities in California to raise revenues. If the initiative had passed, it would have increased the threshold of votes required to pass tax-raising measures by cities and counties from a simple majority to a two thirds majority. A deal was struck between the state legislature and industry, by which industry withdrew the initiative in return for a 12-year moratorium on adoption of new taxes on soda (113).	No new soda taxes may be imposed in California until 2031.
In February 2018, the National Institutes of Health in the USA launched a clinical study known as Moderate Alcohol and Cardiovascular Disease, which was intended to establish the impact of one serving of alcohol daily on cardiovascular diseases compared with a no alcohol intake group (114).	Shortly after launch of the project, complaints and media reports pointed to the possibility of alcohol industry influence; for example, in the development of the scientific premise of the study in the direction of demonstrating a beneficial health effect of moderate alcohol, while missing harms related to cancer and heart failure (115).	The study was ended after an independent review.
In 2016, the South African Government became the first in the African region to announce the introduction of an SSB tax based on sugar content as a public health measure to reduce obesity.	First, industry underscored its economic importance and the potential job losses and other economic harms that may arise from the tax. Second, industry discussed self-regulation and voluntary measures as a form of policy substitution. Third, industry misused or disputed evidence to undermine the perceived efficacy of the tax. Finally, considerations for small business and their ability to compete with multinational corporations featured in the industry response (116).	The industry response in South Africa can be instructive for other countries contemplating the introduction of similar measures.

SSB: sugar-sweetened beverage; USA: United States of America.

5.2 Exercises for Part A and Part B

5.2.1 Questions and discussion items

1. Describe how you would use the human rights framework to address a public health problem arising in the context of healthy diets and physical activity.
2. Explain how the right to health is relevant to your discipline, as a public health practitioner or a lawyer.
3. What opportunities does the right to health provide for influencing the evolution of law and policy on healthy diets and physical activity?
4. Identify institutions responsible for implementing the legal and policy frameworks, and discuss how you might engage them in the development of relevant interventions to promote healthy diets and physical activity.
5. Identify any special measures (affirmative action) implemented by your country for promotion of healthy diets and physical activity for women and girls. What challenges are likely to be encountered and how might they be avoided?
6. For each of the above policy documents, identify at least three actions that your country could undertake to achieve the identified objectives.
7. Can you identify any policy gaps in the above documents? If so, why do you think these gaps exist and what can be done to address them?
8. What challenges might limit the implementation of the above policies in your country? What do you think could be done to surmount those challenges?
9. 9. List the major government sectors that affect the promotion of healthy diets and physical activity, and describe their respective input.
10. 10. Can you give three reasons why your government should be especially concerned about protecting children from marketing of NABs?
11. Can you identify the key stakeholders to be involved in the regulation of marketing of foods to children in your country?
12. Explain the opportunities that a human rights approach offers for the promotion of healthy diets and physical activity. What practical implications does the approach have for:

    a. the government (and the various institutions that make up the government);
    b. civil society organizations;
    c. individuals; and
    d. the food industry?

13. In what ways might trade agreements affect prevention of NCDs? How would you suggest that negative impacts of such agreements might be mitigated and positive impacts enhanced? What role do human rights play in such strategies?

5.2.2 Scenario 1

Review the following scenario in the context of marketing.

Country X, in Africa, is an LMIC. The Ministry of Education has received a proposal for a memorandum of understanding (MoU) with the Fun Drinks Company, a multinational manufacturer of the drink 'FunJuice', which is a fruit juice sweetened with added sugar and is a favourite among children. The proposed terms include the following:

(i) Fun Drinks Co. will provide funds to facilitate the ministry to host the National Schools Music and Art Festival for the next 5 years following the signing of the MoU.
(ii) The Ministry of Education will allow Fun Drinks Co. to mount billboards advertising FunJuice.
(iii) Fun Drinks Co. will print and distribute free T-shirts emblazoned with its logo and words promoting the drink.

What steps might the Ministry of Education take, and what principles should it apply, to limit the adverse effects this relationship might have on children's health in the context of healthy diets and physical activity?

5.2.2 Scenario 2

Read this extract from a 2015 publication (117):
The 'nanny state' has become a popular metaphor in debates about public health regulation. Associating a new law or policy with 'nanny' is a stinging criticism, especially in western, liberal, democracies where liberty, independence and individual autonomy are prized values. The metaphor has force because it associates government action with a fussing, over-bearing nanny who intrudes into the private lives of citizens and treats them as infants who cannot be trusted to make their own decisions.

In your view, should governments:

(a) seek to persuade people to eat more healthily by disseminating information about healthy diets;
(b) promote healthy diets through population-wide policy measures such as taxation and regulation of markets; or
(c) do nothing at all and leave the decision about diets to consumers and market forces?

5.2.3 Scenario 3

Some 20 years ago, X Hotels Limited acquired a parcel of land adjacent to a primary school and created parking space for its patrons. A recent joint investigation by the Ministry of Lands, the Ministry of Education and the police has established that the property was originally set aside for a play area. The two ministries have organized a public forum to obtain public views on the measures that should be taken with respect to the land. Grounding your arguments on the human right to health, and the duty to promote physical activity as an integral aspect of that right, write a memorandum of about 1000 words supporting the restoration of the land as a play area for the children.

5.3 Further reading

Scottish Human Rights Commission (no date). A human rights based approach: an introduction (https://www.scottishhumanrights.com/media/1409/shrc_hrba_leaflet.pdf).

Hastings G, Stead M, McDermott L, Forsyth A, MacKintosh A, Rayner M et al. (2003). Review of research on the effects of food promotion to children: final report. Glasgow: Centre for Social Marketing (https://www.researchgate.net/publication/242490173_Review_Of_Research_On_The_Effects_Of_Food_Promotion_To_Children).

The human rights-based approach: statement of common understanding. State of the World's Children, New York: United Nations Children's Fund; 2004 (https://www.unicef.org/media/84796/file/SOWC-2004.pdf).

NCD Alliance (2011). Non-communicable diseases (NCDs): the human rights factor (https://ncdalliance.org/sites/default/files/rfiles/NCDs%20and%20Human%20Rights%20-%20longer%20doc%20(1%20July%202011).pdf).

Frank J, Jepson R (2013). High-risk versus population prevention strategies for NCDs: Geoffrey Rose revisited in the twenty-first century. In: McQueen DV, editor. Global Handbook on Non-communicable Diseases and Health Promotion. Atlanta: Springer New York, 3–19 (https://www.research.ed.ac.uk/en/publications/high-risk-versus-population-prevention-strategies-for-ncds-geoffr).

The difference it makes: putting human rights at the heart of health and social care. London: British Institute of Human Rights; 2013 (https://www.bihr.org.uk/blog/the-difference-it-makes-putting-human-rights-at-the-heart-of-health-and-social-care).

Global status report on noncommunicable diseases. Geneva: World Health Organization; 2014 (https://apps.who.int/iris/bitstream/handle/10665/148114/9789241564854_eng.pdf).

Gostin LO (2014). Global health law. Harvard University Press (http://dx.doi.org/10.4159/9780674369870).

Toebes B (2014). Health and human rights: in search of the legal dimension. SSRN Electronic Journal (http://dx.doi.org/10.2139/ssrn.2456157).

Porsdam Mann S, Bradley VJ, Sahakian BJ (2016). Human rights-based approaches to mental health: a review of programs. Health Hum Rights 18(1):263–76 (https://pubmed.ncbi.nlm.nih.gov/27781015).

Advancing the right to health: the vital role of law. Geneva: World Health Organization; 2017 (https://www.idlo.int/fr/publications/advancing-right-health-vital-role-law).

Garde A (2018). Global health law and non-communicable disease prevention: maximizing opportunities by understanding constraints. Research Handbook on Global Health Law. Edward Elgar Publishing, 389–426 (http://dx.doi.org/10.4337/9781785366543.00021).

Ó Cathaoir K, Hartlev M, Olsen CB (2018). Global health law and obesity: towards a complementary approach of public health and human rights law. In: Burci GL & Toebes B (eds.), Research Handbook on Global Health Law, Edward Elgar Publishing. 427–59 (http://dx.doi.org/10.4337/9781785366543.00022).

The global burden of disease study. Lancet. 2019;396(10258):1129–306 (https://www.thelancet.com/gbd).

Learning objectives:

- Describe the relevant regional legal and policy frameworks on healthy diets and physical activity in the context of NCDs, and their role in addressing NCDs
- Describe the nature of regional human rights obligations and the concept of limitation of rights in the context of NCDs
- Describe how to apply relevant legal or policy measures that mitigate risk factors for NCDs associated with unhealthy diets and physical inactivity in the African region

PART C: AFRICAN REGIONAL CONTEXT

CHAPTER 6
REGIONAL LEGAL FRAMEWORK

6.1 Constitutive Act of the African Union

One of the objectives of the African Union (AU), set out in Article 3(n) of the Constitutive Act of the African Union (118), is to "work with relevant international partners in the eradication of preventable diseases and the promotion of good health on the continent". All coordinating actions and decisions on policies in areas of common interest to Member States (e.g. food, agriculture, education, health and social security) are to be taken by the Executive Council, and all these actions and decisions may have implications for the prevention and control of NCDs. Article 14 of the Act establishes "Specialized Technical Committees", one of which is the Committee on Health, Labour and Social Affairs. The powers donated to the committees under Article 15 can be harnessed concertedly for prevention and control of NCDs. They include the power to prepare projects and programmes, to supervise decisions taken by AU organs, and to submit reports and recommendations on implementation of the Constitutive Act.

6.2 African Charter on Human and Peoples' Rights

Article 16 of the African Charter on Human and Peoples' Rights (119), which guarantees the right to health, provides that:

(1) Every individual shall have the right to enjoy the best attainable state of physical and mental health. (2) States parties to the present Charter shall take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick.

Article 18(1) requires States parties to protect the family and "take care of its physical and moral health". Article 24 provides that all peoples "have the right to a general satisfactory environment favourable to their development". Development is a holistic concept that entails economic, social and cultural aspects of life, including health and well-being. Indeed, read together with the UN Declaration on the Right to Development (120), African States should "formulate appropriate national development policies that aim at the constant improvement of the well-being of the entire population and of all individuals…" (120). Moreover, the African Commission on Human and Peoples' Rights (the implementing organ of the Charter) has emphasized that the right to health cannot be viewed in isolation from other rights. Thus, the African Commission on Human and Peoples' Rights has recognized the inseparability of the rights to food, human dignity, health, education, work and political participation (121).

In addition, through the *Principles and guidelines on the implementation of economic, social and cultural rights in the African Charter on Human and Peoples' Rights* (122), the Commission has expounded the right to health in a broad manner that encompasses measures aimed at dealing with NCDs.

6.3 Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa

The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (123) requires States parties to take deliberate measures that seek to eliminate discrimination against women and girls, and also to extend special protections to women because of their vulnerable status. Article 1(c) requires States parties to "integrate a gender perspective in their policy decisions, legislation, development plans, programmes and activities and in all other spheres of life". Measures taken for the prevention and treatment of NCDs must consider the specific vulnerabilities of wom-

en and girls, and must be fashioned accordingly. Article 14(1) on health requires States parties to ensure that women's right to health is respected and promoted. Under Article 14(2), States parties are obligated to take measures to provide adequate, affordable and accessible health services. In recognition of the value of breastfeeding for infants, Article 14(2)(c) of the protocol requires that States parties "establish and strengthen existing pre-natal, delivery and post-natal and nutritional services for women during pregnancy and while they are breast-feeding".

6.4 African Charter on the Rights and Welfare of the Child

Article 14(1) of the African Charter on the Rights and Welfare of the Child (124) guarantees that "Every child shall have the right to enjoy the best attainable state of physical, mental and spiritual health". States parties are required to take measures to ensure full implementation of this right. Relevant to NCDs are measures to:

- ensure the provision of adequate nutrition, to combat disease and malnutrition;
- ensure appropriate health care for expectant and nursing mothers;
- develop preventive health care and family life education and provision of service; and
- ensure that all sectors of society – in particular, parents, children, community leaders and community workers – are informed and supported.

These provisions reflect the obligations in the CRC, as elaborated in General Comment 15 (60). They also provide guidance on concrete steps that promote healthy diets and physical activity, and address NCDs in children. The African Committee of Experts on the Rights and Welfare of the African Child (the body charged with interpreting and implementing the Charter) has noted that a child's right to health encompasses other rights (e.g. to food, water and development), and can be negatively impacted if those other rights are violated (125).

6.5 Treaty for the Establishment of the East African Community

The Treaty for the Establishment of the East African Community (the "EAC Treaty") (126) is a foundational document. A fundamental principle of the EAC Treaty is a commitment to the protection of human and people's rights, as set out in the African Charter on Human and Peoples' Rights (119). Hence, the EAC Treaty incorporates health obligations under Article 16 of that Charter. Moreover, in Article 118, the EAC Treaty calls upon Member States to cooperate on health activities and to "take joint action towards the prevention and control of communicable and non-communicable diseases". In addition, Member States have undertaken to:

- promote the management of health delivery systems and better planning mechanisms, to enhance efficiency of health care services within the Partner States;
- harmonize national health policies and regulations, and promote the exchange of information on health issues to achieve quality health within the Community; and
- promote the development of good nutritional standards and the popularization of indigenous foods.

Article 81 binds Member States to cooperate to enhance the standard of living through standardization, quality assurance and testing in the context of consumer protection and promotion of health. These principles can be used to standardize food quality for healthy diets. States are also bound to work together in the areas of food security, health, culture, sports and welfare.

CHAPTER 7
REGIONAL POLICY CONTEXT

7.1 Brazzaville Declaration (2011)

In 2011, in the Brazzaville Declaration on Noncommunicable Diseases Prevention and Control in the WHO African Region, ministers of health and heads of delegation committed their governments to developing integrated national action plans and strengthening institutional capacities for NCD prevention and control (127).

7.2 Africa Health Strategy 2016–2030

The Africa Health Strategy (128) provides strategic direction to AU Member States in their efforts to create health sectors that perform better. Strategic Objective 2 seeks to reduce morbidity and end preventable mortality from communicable diseases, NCDs and other health conditions in Africa by "Prioritizing programs to address risk factors and premature mortality from diabetes, cancer, cardio-vascular diseases, respiratory infections, mental health, injuries and other non-communicable diseases with a particular focus on combatting tobacco use, substance abuse and other risk factors" (128).

7.3 Social Policy Framework for Africa (2008)

The Social Policy Framework for Africa (129) is premised on the AU's vision to "build an integrated, prosperous and peaceful Africa, an Africa driven and managed by its own citizens and representing a dynamic force in the international arena". It contains 18 key thematic social issues, each of which highlights and addresses challenges, and provides a broad range of recommended actions to guide and assist AU Member States in formulating and implementing their own national social policies. Section 2.2.4 of the framework recognizes that "Chronic diseases associated with socio-demographic changes, such as obesity and heart disease, are becoming more prevalent". The framework recommends that Member States should "Promote healthy life styles, healthy eating habits, regular physical activity, and adequate rest".

7.4 Agenda 2063: the Africa we want (2015)

Agenda 2063 (130) is the AU's blueprint and master plan for transforming the continent into the global powerhouse of the future. It has seven aspirations that reflect the "desire for shared prosperity and well-being, for unity and integration, for a continent of free citizens and expanded horizons, where the full potential of women and youth, boys and girls are realized, and with freedom from fear, disease and want". Three of the aspirations can provide a basis for action for the prevention and control of NCDs, and for promoting healthy diets and physical activity:

- **Aspiration** 1 – A prosperous Africa based on inclusive growth and sustainable development.
- **Aspiration 3** – An Africa of good governance, democracy, respect for human rights, justice and the rule of law.
- **Aspiration 6** – An Africa, whose development is people-driven, relying on the potential of African people, especially its women and youth, and caring for children.

Paragraph 10 of the agenda document further elaborates the essence of Aspiration 1, forecasting an Africa that is prosperous by 2063, where "African people have a high standard of living, and quality of life, sound health and well-being". Similarly, Paragraph 11 foresees an Africa whose people will be enjoying a high quality of life by 2063, achieved through strategies such as the provision of basic services (e.g. health, nutrition, education, shelter, water and sanitation). Some of the goals can provide a basis for interventions promoting health and nutrition, including for the purposes of healthy diets and physical activity. In addition, these interventions may be linked to specific health-related SDGs – in particular, SDG2 and SDG3.4 (131).

CHAPTER 8 THE WAY FORWARD – STRATEGIES FROM THE AFRICAN REGION FOR ADDRESSING NCDs USING LEGAL AND HUMAN RIGHTS APPROACHES

8.1 Framework for cooperative development

By providing a framework for cooperative development of health policies and laws, human rights serve as a common language between governments as duty-bearers and civil society as rights-holders; they also open up the rights discourse to wider public participation. For example, in Kenya, the Ministry of Health has collaborated closely with civil society in tobacco control; benefiting from technical expertise not only in developing regulations (132) but also in defending them against industry-mounted court action (110). International Institute of Legislative Affairs (IILA), an NGO, has been at the forefront of advocacy against tobacco use in Kenya. IILA participated in drafting regulations that banned smoking in public places, directly lobbied for passage of the Tobacco Control Act and the development of regulations under the legislation and trained public officials in the enforcement of those regulations (132).

8.2 Mobilizing for social justice

A human rights approach can mobilize civil society action towards the realization of the right to health. Government departments can benefit from the research, capacity-building and dissemination programmes enabled through the resources marshalled by civil society. Civil society has also been able to mobilize against industry in the interest of the public. In the case of *British American Tobacco v The Environmental Action Network* (133) in Uganda, a public interest group filed a case seeking that the court declare that British American Tobacco's failure to warn smokers about the harm associated with its products was a violation of the right to life. The claim did not succeed, but serves as an example of how human rights can be used as a rallying point for social justice. In South Africa, the Constitutional Court's decision in the case of *Minister of Health v Treatment Action Campaign (No 2)* (134) is credited for having a significant impact on the South African Government's policies on HIV generally, and specifically on the issue of treatment for people living with HIV (135). These precedents on access to HIV medication have informed advocacy and litigation on access to NCD medication in other contexts.

8.3 Litigation

When rights are violated, wide publicity – perhaps through public critique and remonstration or through litigation – can be used to hold governments to account. However, this is an adversarial strategy that may be ignored, may create animosity towards a rights discourse, and has time and cost implications. Nevertheless, sometimes a remedy may have wide reach and help not just the individual who suffered the wrong but also the public (so-called strategic litigation). Box 8.1 gives examples of litigation used to address health rights in the region. Although these cases do not all directly address NCDs, they are indicative of the willingness of courts to address health rights.

Box 8.1

EXAMPLES OF LITIGATION IN EAST AFRICA TO ADDRESS HEALTH RIGHTS

Country	Industry tactic	Outcome
Kenya	Milicent Awuor Omuya and Another v Attorney General and 4 Others [2016] (136) The High Court of Kenya held that a maternity hospital had violated the right to human dignity and the right to health when its staff mistreated women who had given birth there and had been detained because they were unable to settle medical fees. The County Government of Nairobi was ordered to pay them compensation.	The county government's responsibility was based on human rights standards defined in the Constitution and international human rights instruments.
Kenya	Nyumbani Children's Home v Ministry of Education & the Attorney General [2004] (137) Some 91 children sought a pronouncement that a policy barring admission of HIV-positive children in public schools was discriminative, hence unconstitutional. The parties reached an agreement and the offending policy was stopped.	Ending the policy would likely benefit many pupils even if they were not part of the case.
Kenya	Mark Ndumia Ndung'u v Nairobi Bottlers Ltd & another [2018] (138) A beverage company failed to include the same nutritional and other information on its products in glass bottles as it offered on its products in plastic bottles. The petitioner suggested that low-income consumers were more likely to purchase the product in glass bottles. The High Court of Kenya decided that this practice was discriminatory and ordered that the information also be provided on the glass bottles.	In the judgement, the Court cited General Comment 9 of the UNCESCR and a decision of the African Commission on Human and Peoples' Rights.
Uganda	Center for Health, Human Rights and Development, et al. v Nakaseke District Local Administration [2015] (139) The High Court of Uganda decided that an expectant woman's right to basic medical care had been violated when a public hospital did not render the necessary intervention when she presented with obstructed labour, leading to her death.	The Court held that the government was liable for failure to meet its obligations under law. Responsibility lay squarely on the government and its institutions.
Uganda	Asiimwe v Leaf Tobacco & Commodities (U) Ltd [2014] (140) The High Court of Uganda ordered a tobacco manufacturer to stop its operations in a residential area and relocate because emitting tobacco smoke, dust and smell in the area violated the inhabitants' right to a clean and healthy environment.	The decision was based on the public's right to a clean and healthy environment as envisaged in the law.

UNCESCR: United Nations Committee on Economic, Social and Cultural Rights.

8.4 Periodic reporting

Human rights instruments usually have reporting mechanisms through which governments are obligated to file reports on the status of implementation of those instruments. For example, under the ICESCR, each State party is required to submit a report to the UNCESCR documenting how it has implemented the articles of the treaty. The report is reviewed by UNCESCR, which then invites the State for a consensus dialogue before it drafts concluding observations. Members of civil society are allowed to submit a "shadow report" before the Committee finalizes its process. A shadow report may contain an account of civil society's views on the implementation of the various rights in the treaty, including the right to health (141-143); the report provides an opportunity to present a review of government measures for NCD prevention and control.

8.5 Exercises for Part C

1. Describe how the right to health is related to other human rights in the African region.

2. Describe common themes in the global and regional policy context on healthy diets and physical activity.

3. Review the materials on global and regional policy contexts, and describe the extent to which they are based on – and seek to enhance – human rights, and specifically the right to health.

4. What opportunities does a collective regional and global approach (compared with individual country initiatives) afford in the promotion of healthy diets and physical activity?

5. Can you identify some of the challenges a country may face in implementing the global and regional NCD policy frameworks? How might these challenges be mitigated?

8.6 Further reading

Marquez P, Farrington J. The challenge of non-communicable diseases and road traffic injuries in sub-saharan Africa. An overview. Washington, DC: World Bank; 2013 (https://documents.worldbank.org/en/publication/documents-reports/documentdetail/844381468209068874/thechallenge-of-non-communicable-diseases-androad-traffic-injuries-in-sub-saharan-africa-anoverview).

Nyaaba GN, Stronks K, de-Graft Aikins A, Kengne AP, Agyemang C (2017). Tracing Africa's progress towards implementing the non-communicable diseases global action plan 2013–2020: a synthesis of WHO country profile reports. BMC Pub Health 17(1) (https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-017-4199-6).

Kraef C, Juma PA, Mucumbitsi J, Ramaiya K, Ndikumwenayo F, Kallestrup P et al. (2020). Fighting non-communicable diseases in East Africa: assessing progress and identifying the next steps. BMJ Glob Health 5(11) (https://pubmed.ncbi.nlm.nih.gov/33184064/).

Learning objectives:

- Explain the legal and fiscal measures taken by specific countries to promote healthy diets and physical activity
- Assess and describe the success or failure of specific countries in implementing their legal and fiscal commitments
- Recommend steps that can be taken to improve the law and fiscal policy, to effectively promote healthy diets and physical activity

PART D:
EAST AFRICAN SUBREGIONAL CONTEXT

CHAPTER 9
KENYA

This chapter outlines the policy and legal framework that promotes healthy diets and physical activity in Kenya. Annex 3 provides information on restrictions on marketing of foods and NABs to children, and regulation of nutrition labelling and product formulation in Kenya (182).

Kenya is "experiencing an increase in noncommunicable diseases, obesity, and other conditions associated with urbanisation and modernisation, less active lifestyles …" (144). Indeed, the trajectory is such that NCDs (notably diabetes, cancers, cardiovascular diseases and chronic respiratory diseases) are on an upward trend compared with communicable diseases (145). Kenya faces the double burden of an insufficiently resolved communicable disease problem and an increasing prevalence of NCDs (146) (see Box A2.1 in Annex 2).

9.1 Legal and policy overview

9.1.1 Constitution of Kenya

The Constitution of Kenya provides an overarching framework to guide NCD prevention and control measures (147). It recognizes the right of everyone to the highest attainable standard of health, which includes the right to health care services (art. 43). Article 43 also guarantees economic and social rights, including the right to accessible and adequate housing, reasonable standards of sanitation, freedom from hunger and access to adequate food of acceptable quality, and clean and safe water. The Constitution also guarantees consumers the right to goods and services of reasonable quality and to the protection of their health and safety (art. 46). The Constitution also allows for the limitation of rights, providing courts with tools for balancing competing commercial and human rights claims. Industry practice that violates the right to health may be struck down in the interest of public health. For example, litigation on tobacco control has shown that courts are not willing to allow commercial claims couched as constitutional rights to trump the government's obligation to protect the health of the Kenyan public (110).

9.1.2 Physical Planning Act 1996

The Physical Planning Act (148) provides processes for preparing physical development plans for any government land, trust land or private land within the area of authority of a county council, for the purpose of:

- improving the land and providing for the proper physical development of such land;
- securing suitable provision for transportation, public purposes, utilities and services, commercial, industrial, residential and recreational areas, including parks, open spaces and reserves; and
- making suitable provision for the use of land for building or other purposes.

Public spaces can also be taken into account, to encourage active transport and recreational spaces with a view to promoting active lifestyles.

9.1.3 Traffic Act 2012

The Traffic Act (149) controls the use of roads by motorists while taking into account the safety of other users such as pedestrians. Spaces designated for foot traffic (e.g. pedestrian crossings and pavements) are protected through punitive sanctions, assuring relative safety during walking. The relevant minister may also develop a highway code through which lanes may be designated for certain modes of transport (e.g. bicycles). The Traffic Act enables the relevant enforcers to create a road safety culture by enforcing speed limit requirements and proper road usage.

9.1.4 National Strategy for the Prevention and Control of Non-Communicable Diseases (2015)

The National Strategy for the Prevention and Control of Non-Communicable Diseases (146) is the first strategy to address NCDs in Kenya. It was adapted from the Global Action Plan on NCDs (2), and aims to inform stakeholders at all levels (national, county, subcounty and community) on strategic directions to be considered when developing implementation plans on the prevention and control of NCDs. The strategy covers cancers, cardiovascular diseases, chronic respiratory diseases and diabetes and the following risk factors: tobacco consumption, inadequate physical activity, unhealthy diets and harmful use of alcohol.

9.1.5 National Physical Activity Action Plan 2018–2023

The National Physical Activity Action Plan 2018–2023 (150) aims to reduce the levels of insufficient physical activity by 5% by 2023, through the following:

- developing and disseminating national legislation, policies and guidelines that promote physical activity;
- creating public awareness on the health benefits of physical activity;
- strengthening implementation of the physical activity component of the school health policy; and
- supporting and initiating implementation of programmes that promote physical activity in community settings (e.g. private and public institutions, workplaces, health facilities, villages and cities).

9.1.6 Kenya Health Policy 2012–2030

The Kenya Health Policy 2012–2030 notes that NCDs will be the leading contributors to the high burden of disease in the country (151). The document highlights six policy objectives, which lay out the following strategies for halting and reversing the rising burden of NCDs:

- ensure universal access to interventions addressing recognized NCDs in the country;
- ensure that services relating to NCDs are of high quality, with a view to maximizing the services the population has access to;
- strengthen advocacy for health-promoting activities aimed at preventing increased burden from NCDs;
- establish programmes for the prevention and control of NCDs;
- establish interventions that directly address marginalized and indigent populations affected by NCDs;
- design and implement integrated health services provision tools, mechanisms and processes, with a view to enhancing comprehensive control of NCDs; and
- decentralize screening for NCDs to the lower levels (of health service provision), to increase access.

9.1.7 National Nutrition Action Plan 2012–2017

The National Nutrition Action Plan 2012–2017 serves as a road map for coordinated implementation of nutrition interventions by the government and nutrition stakeholders (152). Relevant strategic objectives include prevention, management and control of diet-related NCDs; nutrition in schools, and public and private institutions; and nutrition knowledge, attitudes and practices among the population.

9.1.8 National School Meals and Nutrition Strategy 2017–2022

The National School Meals and Nutrition Strategy 2017–2022 outlines a strategy for the design and implementation of nutrition-sensitive school meals in Kenya (153). It recommends a three-pillar approach for school meals:

- regular provision of meals every school day throughout the school year;
- acknowledgement of nutrition and nutrition education as core components of school meals; and
- linking smallholder farmers with the demand for school meals by procuring directly from these suppliers where possible.

The strategy also aims to increase awareness and intake of adequate, locally available and nutritious food among school children and their communities; improve the enrolment, attendance, retention, completion and learning outcomes of school children with equity; promote local and inclusive development; promote partnerships and multisectoral coordination for complementary support and effective implementation; and strengthen related governance and accountability.

9.1.9 National Guidelines for Healthy Diets and Physical Activity (2017)

The National Guidelines for Healthy Diets and Physical Activity (154) supplement the Kenya National Strategy for the Prevention and Control of Non-Communicable Diseases 2015–2020 (155). The specific objectives of the guidelines are to:

- provide principles of healthy diets for the general population;
- establish a set of dietary guidelines for the Kenyan population throughout the life cycle;
- provide recommendations for physical activity for all age groups, including those with special needs;
- define roles and responsibilities of various stakeholders in promoting healthy diets; and
- provide guidance for advocacy and resource mobilization for promotion of healthy diets.

The guidelines describe the nutritional requirements to promote healthy diets at different stages of the life cycle (pregnancy and lactation, early childhood, late childhood, adolescence, adulthood and old age). They also provide information on meal planning, preparation and cooking methods, and food safety and hygiene. Chapter 7 of the guidelines provides an implementation framework that covers the roles and responsibilities of various stakeholders, the coordination framework, capacity development, advocacy, communication and social mobilization, resource mobilization, and monitoring and evaluation. Relevant government departments and stakeholders identified include the Ministry of Health; Ministry of Agriculture; Ministry of Education; Ministry of Water and Irrigation; Ministry of East African Community, Labour and Social Protection; Ministry of Sports; development partners; academic and research institutions; media; private sector; and the County Health Department. For example, the roles and responsibilities of the Ministry of Education include establishing and strengthening health clubs in schools, supporting nutrition assessment for children attending schools and establishing programmes that help learners make better food choices.

9.2 Further reading

The Kenya Non-Communicable Diseases & Injuries Poverty Commission Report. Nairobi: Ministry of Health; 2018 (https://static1.squarespace.com/static/55d4de6de4b011a1673a40a6/t/5b637739562fa77c7bbf430a/1533245242346/Kenya+Report+layout+23-07-18_JUSTIFIED.pdf).

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CHAPTER 10
TANZANIA

This chapter outlines Tanzania's legal framework, policies and fiscal measures that promote healthy diets and physical activity. Annex 4 provides information on regulation of marketing and labelling of food products, and promotion of physical activity in Tanzania (183).

Rapid demographic transition underlined by urbanization and shifting lifestyles has had an impact on healthy diets and physical activity in Tanzania (156). About one third of total deaths are NCD-related deaths, with cardiovascular diseases contributing a major share. In adults, physical inactivity is more prevalent among females (at 7.1%) than among males (at 5.8%); however, in adolescents the numbers are much higher, with females at 86% and males at 78.2% (see Box A2.2a in Annex 2).

For Zanzibar, most of the people who did not engage in vigorous activity (52.1%) were female (70.6% compared with 31.8% of men) (157). A high proportion of those surveyed (97.9%) were eating fewer than five servings of fruit and/or vegetables per day (again, negatively skewed against females). While the mean body mass index (BMI) stood at 24.3, the average percentage of overweight persons was 36.6%, with 12.1% more females than males being overweight. The same trend was observed with regard to obesity (see Box A2.2b in Annex 2).

10.1 Legal and policy overview

10.1.1 Constitution of the United Republic of Tanzania

The Constitution contains no express recognition of the right to health; however, article 30(2)(b) of the Constitution allows the exercise of broad powers to pass laws that protect the public health (158). In addition, article 9(i) requires the State and its agencies to direct policies and programmes towards ensuring that the use of national wealth is geared towards "the eradication of … disease". These provisions can provide a basis for NCD-related interventions. In addition, the limitation clause in the Constitution – which states that fundamental rights cannot be exercised in a manner "that causes interference with or curtailment of the rights and freedoms of other persons or of the public interest" – can be deployed by courts to balance commercial interests with the right to health, particularly in the context of NCDs (158).

10.1.2 Second National Five-Year Development Plan 2016/17–2020/21

The Second National Five-Year Development Plan (159) recognizes the importance of nutrition in the achievement of various SDGs, including reducing the risk of developing communicable diseases and NCDs. The core objectives of the plan include transforming Tanzania into a semi-industrialized nation, accelerating economic growth to reduce poverty, and improving quality of life and human well-being.

10.1.3 Strategic and Action Plan for the Prevention and Control of Non-Communicable Diseases (2016–2020)

The Strategic and Action Plan for the Prevention and Control of Non-Communicable Diseases (160) targets cancers, cardiovascular diseases, chronic respiratory diseases, diabetes, mental health, sickle cell diseases, injury and trauma and associated disability. It covers the four main NCD risk factors of tobacco use, inadequate physical activity, unhealthy diets and harmful use of alcohol.

10.1.4 National Multisectoral Nutrition Action Plan (2016–2021)

The National Multisectoral Nutrition Action Plan July 2016–June 2021 (161) contains the implementation plan for the 2016 National Food and Nutrition Policy and its 10-year Implementation Strategy (2015/16–2025/26), which is coordinated by the Prime Minister's Office. Annex 4 of the National Multisectoral Nutrition Action Plan contains the Action Plan to Scale Up Prevention and Management of Diet Related Non-Communicable Diseases (DRNCDs) that aims to "Develop/review standards and bylaws and sensitize law enforcers on issues related to healthy lifestyles".

10.1.5 The Tanzania Food and Nutrition Centre (TFNC) Strategic Plan (2016–2021)

The Tanzania Food and Nutrition Centre (TFNC) was established by the government through the Tanzania Food and Nutrition Act 1973 (162). The purpose was to coordinate policy and action on nutrition primarily between agriculture and health under the "nutrition planning" movement. The TFNC Strategic Plan 2016–2021 (163) outlines five key objectives for the period. Under Objective C the TFNC will provide strategic leadership at the national level, including developing and reviewing food and nutrition policies, guidelines, strategies, protocols and standards that will guide and harmonize the efforts employed by all nutrition players in the country. The strategies to be adopted include developing new guidelines, strategies, protocols, standards and regulations; and conducting four monitoring and evaluation exercises on food and nutrition and nutrition-related activities within local government areas and other key players (those exercises were to be conducted by June 2020).

10.1.6 National Food and Nutrition Policy (2016–2021)

The National Food and Nutrition Policy (2016–2021) (164) includes as an action area the "Promotion of healthy diet and prevention of obesity and diet-related NCDs". Areas covered include dietary guidelines, food labelling, nutrient declaration (i.e. back-of-pack labelling), front-of-pack labelling, menu labelling, and regulation of marketing of food and beverages to children.

10.1.7 National Nutrition Social and Behaviour Change Communication Strategy (2013–2018)

The National Nutrition Social and Behaviour Change Communication Strategy (165) includes Strategic Objective 2, which "focuses on an enabling environment for nutrition social and behaviour change and requires the engagement of all levels and sectors of society. A high visibility and enhanced positioning of nutrition in society through leadership, celebrities, VIPs, and mass media, positive perceptions of social norms and gender roles favorable to nutrition, supportive policies, services, systems, laws, and institutions facilitating nutrition social and behavior changes, and sufficient resources mobilized and available to support nutrition social and behavior change are among the key components under this objective".

10.2 Fiscal measures

10.2.1 Excise (Management and Tariff) Act 2008

The Excise (Management and Tariff) Act provides for the control of manufacture of excisable goods and for the collection of excise duties (166). The Act is administered by the Commissioner-General and provides for enforcement through penalties, forfeitures and seizures. While it does not specifically define sugar-sweetened beverages as the basis of taxation, it applies a levy on "flavoured waters" including soda. The Act defines sugar as including "(a) any saccharine substance, extract or syrup; (b) rice; (c) flaked maize and any other description of corn which in the opinion of the Commissioner-General is prepared in a manner similar to flaked maize; (d) any other material capable of being used in brewing except malt, corn, hops, hop concentrate or hop oil". The tax is imposed on a per litre basis of the product containing added sugar or other sweetening matter or flavour, and not on the measured sugar content.

CHAPTER 11
UGANDA

This chapter outlines Uganda's policies and fiscal measures that promote healthy diets and physical activity. Annex 5 provides information on regulation of marketing and labelling, institutional structure on physical activity and legislation on physical activity in Uganda (184).

In the late 1950s, Uganda recorded near zero incidences of coronary heart disease, but recently it has seen a marked increase in cardiovascular diseases, diabetes, cancers and chronic respiratory conditions (167). The country is experiencing an epidemiological shift characterized by demographic and nutritional transitions. A larger proportion of the population now lives in urban areas (168) where consumption of pre-packaged food is high (169). A study conducted in Kampala in 2012 found that demand for fast foods was high in urban settings, and tended to be influenced by factors such as time spent away from home, level of education, disposable income, age of a person and size of a household (170). Fast-food chains have entered the local food environment, and NCDs such as systemic hypertension, cardiovascular diseases and cancers are on the increase (171). The risk associated with poor nutrition and physical inactivity is increasing at the population level (see Box A2.3 in Annex 2).

11.1 Legal and policy overview

11.1.1 Constitution of Uganda

There is no direct recognition of the right to health in the Constitution of Uganda. However, the Constitution contains other rights that can be interpreted broadly to encompass the right to health or as being health-related (e.g. the right to life; respect for dignity; guarantee of equality; freedom from torture or inhumane, cruel and degrading treatment; and right to privacy) (172). In addition, Ugandan courts have rendered decisions that have broadly recognized an enforceable right to health (172).

11.1.2 Uganda Vision 2040 (2021)

Uganda Vision 2040 (173) provides development paths and strategies to operationalize the National Vision Statement, which is "A transformed Ugandan society from a peasant to a modern and prosperous country within 30 years". The vision aims to transform Uganda from a predominantly peasant and low-income country to a competitive upper-middle-income country. The vision commits Uganda to improving the standards of living of its population by improving their health and nutrition status, water and sanitation conditions, and by increasing their social protection. The document proposes a paradigm shift from a facility-based to a household-based health delivery system. The main thrust of this paradigm is an empowerment of households and communities to take greater control of their health through the promotion of healthy practices and lifestyles. Another key health strategy is to improve the nutrition status of the population, especially for young children and women of reproductive age.

11.1.3 Health Sector Development Plan 2015/16–2019/20

The Health Sector Development Plan (174) is the second in a series of six 5-year plans aimed at achieving the Uganda Vision 2040 of a healthy and productive population that contributes to socio-economic growth and national development. The Plan notes that the most significant risk factors are alcohol use, tobacco use, household air pollution, childhood underweight, iron deficiency and high blood pressure, which together are responsible for over 16% of all disease conditions. The strategic objectives of the Plan include the provision of NCD prevention and control services and the implementation of food and nutrition services. Recognizing the increased burden of NCDs in Uganda, the Plan proposes programme areas and key interventions, as summarized in Box 11.1.

Box 11.1

PROGRAMME AREAS AND KEY INTERVENTIONS NCDs CONTROL ACCESS ACROSS THE LIFE COURSE

Note: Levels of provision are: 1 = community; 2 = dispensary/health centre; 3 = health centre; 4 = primary hospitals (general/ health centre); 5 = secondary hospitals (regional); 6 = tertiary hospitals (national).

Programmes or service areas	Key interventions	Lowest level of provision
NCD prevention and control	Develop and implement communication strategies for NCD prevention and control, and for MNS [mental, neurological and substance use] disorders	MoH
	Institutional screening for NCD risks	2
	Strengthen the regulatory framework – develop and implement the Alcohol Control Policy, Tobacco Control Policy, and Drug Abuse Control Policy	MoH
	Develop an NCD policy and guidelines on diet and physical activity	MoH
Capacity-building	Improve health worker skills to manage NCDs, and to manage common mental, neurological and substance use disorders including rehabilitative health care workers at all levels of care, including the community and households	4
Management of common NCDs	Develop an NCD policy and guidelines on NCD management	MoH
	Ensure the availability of NCDs drugs	3
	Ensure the availability of basic equipment for screening, management and monitoring of NCDs	2
	Ensure the availability of rehabilitative appliances (orthopaedic, visual and hearing devices)	5
	Establish functional surveillance, monitoring and research to support prevention and control of NCDs	2
	Management of NCDs including conditions related with drug abuse and harmful use of alcohol at all levels of care	2
	Scale up services for management of NTDs (blinding diseases or conditions, hearing impairment and deafness, osteoarthritis, osteoporosis, muscle weaknesses and dementia)	5
	Conduct advocacy and communication for behaviour change aimed at injury prevention, eliminating gender and disparities that negatively impact public health and development	1
	Provide psychosocial interventions to people affected by violence, conflicts and disasters	1

MoH: Ministry of Health; NCD: noncommunicable disease; NTD: neglected tropical disease.
Source: Ministry of Health, Uganda (174).

11.1.4 Uganda Nutrition Action Plan 2011–2016

The Uganda Nutrition Action Plan (175) has expired; however, the plan is indicative of the strategic direction that Uganda took on the issue of nutrition. The core objective of the plan was to tackle the crisis of malnutrition in the country. The document acknowledged the double burden of malnutrition (the increasing coexistence of obesity and malnutrition in communities across the country) and identified four key areas of intervention:

- promotion of key maternal, infant and young child feeding and nutrition practices to improve awareness and increase targeted healthy feeding behaviours;
- support for households and communities to increase access to and consumption of diversified food throughout the year;
- provision of care and support to individuals with severe acute malnutrition; and
- mobilizing the community to promote adoption of healthy nutrition behaviours.

11.2 Fiscal measures

11.2.1 Taxation on sugar-sweetened beverages

The Uganda Revenue Authority is a central body for the assessment and collection of specified revenue (176). It operates as an agency of the government that will operate under the general supervision of the Minister for Finance. The functions of the authority are to:

- administer and give effect to the laws or the specified provisions of the laws set out in the First Schedule of the Uganda Revenue Authority Act (177-180), and for this purpose to assess, collect and account for all revenue to which those laws apply;
- advise the Minster for Finance on revenue implications, tax administration and aspects of policy changes relating to all taxes referred to in the First Schedule; and
- perform such other functions in relation to revenue as the Minister may direct.

The Minister for Finance has power to define the specific taxes to be collected by the authority. In the case of sugar-sweetened beverages, certain taxes have been specified under legislation, as outlined below.

11.2.2 Excise Tariff Act 1954

Under the Excise Tariff Act (178), excise duty shall be charged for the goods manufactured in Uganda, and as specified for in the Schedule. Sugar-sweetened beverages are liable for taxation under the Act, a power that can be used to incentivize production of healthier alternatives. The relevant Schedules containing the list of taxable goods can be amended by the action of the responsible Minister, thus providing an opening for influencing the policy process.

11.2.3 Excise Duty (Amendment) Act 2017

Under the Excise Duty (Amendment) Act, taxes are imposed on goods and services as specified in the Second Schedule (181). NABs and fruit and vegetable juices attract excise duty at rates that can be adjusted to provide proper incentives to producers.

11.2.4 Customs Tariff Act 1970

The Customs Tariff Act (180) authorizes the charging of duty (import duty) on goods imported into Uganda at rates specified in its Schedule or other relevant laws.

11.3 Exercises for Part D

1. Using the information in Part D and the data in Annex 2, discuss current trends in NCD prevalence and state the likely impact of any projections.

2. To what extent does NCD epidemiology in these countries reflect gendered patterns, particularly in the context of diet and physical activity? Identify additional factors that may explain differences in the data across genders in your own social context.

3. Having reviewed the domestic legal and policy frameworks for your country as set out above, match those provisions with the relevant NCD-related obligations in the global policy framework. Do the laws cover all the areas contemplated by the global health policy framework? What gaps can you identify? What strategies exist in your country to influence policy to address the gaps?

4. Identify the institutions relevant to implementing the laws and policies on NCDs in your country and explain their roles. Suggest measures that may be taken by those institutions to improve their potential to implement the legal and policy framework on NCDs.

5. Describe the extent to which your country's laws and policies reflect a human rights approach to the promotion of healthy diets and physical activity and the prevention and control of NCDs.

6. Identify any barriers that may prevent implementation of your country's legal and policy frameworks on healthy diets and physical activity and suggest how they might be eliminated or reduced.

7. How could the three countries covered in this toolkit – Kenya, Tanzania and Uganda – cooperate under the Treaty for the Establishment of the East African Community (126) to implement measures that promote healthy diets and physical activity?

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ANNEX 1: ADDITIONAL EXERCISES

A1 Right to health and noncommunicable diseases: accountability through human rights reporting systems

Consider the parallel or shadow reporting mechanism of the United Nations Committee on Economic, Social and Cultural Rights (UNCESCR). How do recent civil society submissions address the right to health, and what gaps are there pertaining to noncommunicable diseases (NCDs)? How might a future submission correct these gaps?

For Kenya, see:

- p 29–30 of the Joint civil society organizations' alternative to the UNCESCR review of the Republic of Kenya (1); and
- p 59–65 of the Kenya Universal Periodic Review (UPR) Stakeholders' Coalition midterm report on Kenya's 2nd cycle UPR (2).

For Uganda, see:

- the Foundation for Human Rights Initiative submission to UNCESCR (3); and
- paragraphs 33–39 of the Uganda Coalition on Economic, Social and Cultural Rights submission to the UPR of Uganda (4).

For Tanzania, see:

- the Joint civil society submission to the UPR Working Group review of the United Republic of Tanzania (5).

A2 Scenario 1

A nongovernmental organization (NGO) has proposed to the city authorities that the city develop a programme that earmarks allotments of land across the city for vegetable gardening. The NGO argues that this is consistent with health policy commitments made by government, and will improve urban food security, enhance the quality of urban diets and reduce risks for NCDs. Implementing the programme will require an audit of land and a rezoning of the land to permit its use for gardening. The NGO lobbies government authorities to provide support in the form of seed provision and free access to water to irrigate the plots. However, the city authorities say that they do not have the funds to support such a programme; also, given the pollution in urban areas, they are concerned that the vegetables would not be fit for consumption. What human rights and other legal obligations does the government have that might apply in this situation?

A3 Scenario 2

The government is considering introducing specific taxation on sugar-sweetened beverages as a strategy to reduce their consumption. A delegation of small traders goes to the government to claim that such a measure will put them out of business and cause hardship for families that depend on the income from the sale of such beverages from informal markets. The large companies producing sugar-sweetened beverages have funded the traders, who are mostly women, to organize and attend the meeting. What do national and international guidance documents, and experience in other countries, suggest should be done? What do human rights documents indicate?

A4 Scenario 3

The government plans to introduce legislation to restrict the advertising of fast foods and sugary drinks targeting children. An alliance of beverage companies and companies controlling large fast-food chains has given notice that it will take the government to court over the planned legislation because it adversely affects their businesses and is discriminatory. How would you advise the government on:

- how it should go about developing its legislation; and
- what national and international policy and rights guidance would favour the introduction of the legislation, noting any provisions unique to children's health.

References for Annex 1

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ANNEX 2: NONCOMMUNICABLE DISEASE DATA FOR COUNTRY PROFILES

This annex provides the detailed noncommunicable disease (NCD) data for Part D of the main report for Kenya, Tanzania and Uganda.

Box A2.1

KENYA NCD PROFILE

a. Mortality data (1)

i. Total NCD deaths (in thousands) (2016)

(1) Both sexes: 77.1

(2) Male: 39.3

(3) Female: 37.8

ii. Age-standardized NCD mortality rate (per 100 000 population) (2016)

(1) Both sexes: 385.1

(2) Male: 418.2

(3) Female: 357.4

iii. Percentage of NCD deaths out of total deaths (2018) (2): 27%

iv. Premature NCD deaths (of those aged under 70 years) (percentage of all NCD deaths) (2016) (3)

(1) Both sexes: 60%

(2) Male: 63%

(3) Female: 57%

b. Proportional mortality (2016) (4)

i. Cardiovascular diseases: 7.8%

ii. Cancers: 10%

iii. Diabetes: 0.8%

iv. Chronic respiratory diseases: 1.3%

c. Risk factors

i. Prevalence of raised blood glucose (age-standardized rate) (2014): 6%

ii. Prevalence of overweight among adults, BMI >25, crude estimate (2016) (5)

(1) Both sexes: 22.6%

(2) Male: 14.5%

(3) Female: 30.5%

iii. Prevalence of obesity among adults, BMI >30, crude estimate (2016) (5)

(1) Both sexes: 6%

(2) Male: 2.5%

(3) Female: 9.4%

iv. Raised blood pressure (SBP >140 or DBP >90) (crude estimate) (2015)

(1) Both sexes: 19.9%

(2) Male: 20.5%

(3) Female: 19.3%

v. Physical inactivity (2016) (6)

(1) Among adults (age-standardized estimate)

a. Both sexes: 15.4%

b. Male: 13.9%

c. Female: 16.9%

vi. Nutrition status

(1) Overweight (BMI for age ±1SD) in school-age children and adolescents aged 5–19 years (7): 11.3%

(2) Stunting prevalence in children aged under 5 years (8): 30.8%

(3) Rate of stunting reduction: 1.05%

vii. **Diet (9)**

Diet	Both sexes	Male	Female
Mean number of days fruit consumed in a typical week	2.5	2.6	2.4
Mean number of servings of fruit consumed on average per day	0.8	0.8	0.7
Mean number of days vegetables consumed in a typical week	5	5	5
Mean number of servings of vegetables consumed on average per day	1.3	1.3	1.3
Percentage who ate less than 5 servings of fruit and/or vegetables on average per day	94%	93.2%	94.8%
Percentage who always or often add salt or salty sauce to their food before eating or as they are eating	23.2%	26.2%	20.3%
Percentage who always or often eat processed foods high in salt	4.3%	5%	3.7%
Percentage who always or often add sugar when cooking or preparing food and beverages at home	83.9%	84.2%	83.5%

viii. **Physical activity (9)**

Physical activity	Both sexes	Male	Female
Percentage with insufficient physical activity (defined as <150 minutes of moderate-intensity activity per week, or equivalent)	6.5%	6.3%	6.8%
Adults (18–69) median minutes of total physical activity on average / day (IQR)	263 (111–436)	308 (121–480)	231 (111–436)
Percentage not engaging in vigorous activity	46.1%	39.2%	52.9%
Adults (18–69) minutes sedentary time on average / day (IQR)	120 (60–80)	120 (60–80)	120 (60–80)

BMI: body mass index; DBP: diastolic blood pressure; IQR: interquartile range; NCD: noncommunicable disease; SBP: systolic blood pressure; SD: standard deviation.

Box A2.2a

TANZANIA NCD RISK FACTOR PROFILE

a. Mortality data (1)

Age-standardized NCD mortality rate (per 100 000 population)				Total NCD deaths (in thousands)		
Year	Both sexes	Male	Female	Both sexes	Male	Female
2016	539	562.7	518.8	134.6	66.7	67.9
2015	538.4	561.3	518.9	130	64.6	65.4

(i) **Percentage of NCD deaths out of total deaths (2016) (4): 34.5%**

(ii) **Number of NCD-related deaths of those aged under 70 years (2016): 7797**

(iii) **Probability (%) of dying between age 30 and 70 years from any of cardiovascular diseases, cancers, diabetes or chronic respiratory diseases (2016): both sexes: 17.9%; male: 18.5%; female: 17.4%**

b. Proportional mortality (2016) (4)

(i)	**Cardiovascular diseases:**	**13.2%**
(ii)	**Cancers:**	**7%**
(iii)	**Diabetes:**	**1.7%**
(iv)	**Chronic respiratory diseases:**	**1.8%**

c. Risk factors

(i)	**Diabetes:**	**6.1%**
(ii)	**Obesity:**	**both sexes: 7.1%; male: 3.4%; female: 10.7%**
(iii)	**Raised blood pressure:**	**both sexes: 20.9%; male: 21%; female: 20.9%**
(iv)	**Physical inactivity (age-standardized estimates):**	**both sexes: 6.5%; male: 5.8%; female: 7.1%**
(v)	**Physical inactivity prevalence, adolescents (crude estimate):**	**both sexes: 82.1%; male: 78.2%; female: 86%**

NCD: noncommunicable disease.

Box A2.2b

ZANZIBAR STEPS REPORT 2011 (10)

Results for adults aged 25–64 years (incl. 95% CI)	Both sexes	Male	Female
Percentage who are overweight (BMI ≥25 kg/m2)	36.6	30.5	42.6
Percentage who are obese (BMI ≥30 kg/m2)	14.3	7.7	20.9
Percentage with raised BP (SBP ≥140 and/or DBP ≥90 mmHg or currently on medication for raised BP)	33	37	29.4
Mean number of servings of fruit consumed on average per day	1.1	1.1	1
Mean number of servings of vegetables consumed on average per day	0.7	0.6	0.7
Percentage who ate less than 5 servings of fruit and/or vegetables on average per day	97.9%	97.6%	98.1%
Percentage with low levels of physical activity (defined as <600 MET-minutes per week)	17.6%	7.4%	26.8%

BMI: body mass index; BP: blood pressure; CI: confidence interval; DBP: diastolic blood pressure; MET: metabolic equivalent; NCD: noncommunicable disease; SBP: systolic blood pressure; STEPS: World Health Organization STEPwise approach to surveillance of NCDs.

Box A2.3

UGANDA NCD, NUTRITION, DIET AND PHYSICAL ACTIVITY PROFILE

Mortality data (2016) (5):

Total number of NCD deaths (in thousands)

Both sexes:	97.6
Male:	49.7
Female:	47.8

Percentage of NCD deaths out of total deaths (4): 34.4%

Number of NCD-related deaths of those aged under 70 years (percentage of all NCD deaths) (2016)

Both sexes:	66%
Male:	70%
Female:	62%

Probability (%) of dying between age 30 and 70 years from any of cardiovascular diseases, cancers, diabetes or chronic respiratory diseases (2016):

Both sexes:	21.9%
Male:	23.8%
Female:	20.3%

Proportional mortality (2016):

Cardiovascular diseases:	10.4%
Cancers:	9%
Diabetes:	1.6%

Chronic respiratory diseases: 1.9%

Risk factors (2016):

Raised blood glucose (2014) (crude estimate):	both sexes: 2.8%; male: 2.7%; female: 3%
Obesity prevalence (2016):	both sexes: 4.1%; male: 1.5%; female: 6.8%
Raised blood pressure (2015):	both sexes: 19.5%; male: 20%; female: 19%
Physical inactivity prevalence (adults) (2016/crude estimate):	both sexes: 5%; male: 4.6%; female: 5.5%
Physical inactivity prevalence (adolescents) (2010):	both sexes: 85.6%; male: 84.7%; female: 86.6%

Nutrition status (7)

Child malnutrition

(i) Overweight (BMI for age ≥+1 SD) in school-age children and adolescents aged 5–19 years: 10.3%

(ii) Prevalence of stunting among children aged under 5 years: 28.9% (11)

Food security

(i) Households consuming adequately iodized salt (15 parts per million or more): 91.5%

Population below minimum level of dietary energy requirement (undernourishment): 25.5%

Population below the international poverty line: 34.6%

Caring practices:

Early initiation of breastfeeding (within 1 hour of birth): 52.5%

Introduction to solid, semi-solid or soft foods in infants aged 6–8 months: 67%

Minimum acceptable diet in children aged 6–23 months: 5.8%

Children with diarrhoea aged under 5 years receiving oral rehydration therapy and continued feeding: 36%

Diet (12)

Fruit and vegetable consumption (in a typical week)

Description	Both sexes	Male	Female
Mean number of days fruit consumed	2.9	2.8	2.9
Mean number of servings of fruit consumed on average per day	1.4	1.3	1.4
Mean number of days vegetables consumed	3.5	3.2	3.8
Mean number of servings of vegetables consumed on average per day	1.3	1.2	1.4
Percentage who ate less than 5 servings of fruit and/or vegetables on average per day	87.8%	88.4%	87.3%

Physical activity

Description	Both sexes	Male	Female
Percentage with insufficient physical activity (defined as <150 minutes of moderate-intensity activity per week, or equivalent)	4.3%	3.7%	4.9%
Median time spent in physical activity on average per day (minutes)	308.6	325.7	285
Percentage not engaging in vigorous activity	49.6%	40.1%	58.4%

Additional data: A countrywide survey revealed that most adults in Uganda do not meet the recommended minimum requirements for fruit and vegetable consumption, with just over 1 in 10 adults meeting the recommended minimum of 5 or more servings of fruit and/or vegetables per day in a typical week (13).

BMI: body mass index; NCD: noncommunicable disease; SD: standard deviation.

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ANNEX 3: Kenya – restrictions on marketing of foods and non-alcoholic beverages to children, and regulation of nutrition labelling and product formulation

A3.1 Restrictions on marketing of foods and non-alcoholic beverages to children

Kenya has no overarching law relating to marketing of foods and non-alcoholic beverages (NABs) to children, but the laws described below contain provisions that relate to advertising requirements.

A3.1.1 Consumer Protection Act 2012

The Consumer Protection Act 2012 aims to protect consumers and prevent unfair trade practices in consumer transactions, to advance the social and economic welfare of consumers (1). A consumer is defined fairly broadly, and the range of activities targeted may reasonably be applied in the context of noncommunicable diseases (NCDs).

Box A3.1

KEY PROVISIONS OF THE CONSUMER PROTECTION ACT 2012 ON THE MARKETING OF FOOD PRODUCTS

Title	Relevant provision
Definition clause: consumer (Section 2)	(a) A person to whom particular goods or services are marketed in the ordinary course of the supplier's business; (b) a person who has entered into a transaction with a supplier in the ordinary course of the supplier's business, unless the transaction is exempt from the application of this Act; (c) a user of particular goods or a recipient or beneficiary of particular services, irrespective of whether that user, recipient or beneficiary was a party to a transaction concerning the supply of those particular goods and services; and (d) franchisee in terms of a franchise agreement, to the extent applicable in terms of this Act.
Purpose of the Act (Section 3(4) of the Act)	The purposes of the Act are to promote and advance the social and economic welfare of consumers in Kenya by: establishing a legal framework for the achievement and maintenance of a consumer market that is fair, accessible, efficient, sustainable and responsible for the benefit of consumers generally; protecting consumers from all forms and means of unconscionable, unfair, unreasonable, unjust or otherwise improper trade practices including deceptive, misleading, unfair or fraudulent conduct; improving consumer awareness and information and encouraging responsible and informed consumer choice and behaviour
Unconscionable representation (Relevant portion of Section 13(2))	It is an unfair practice to make an unconscionable representation. Without limiting the generality of what may be taken into account in determining whether a representation is unconscionable, there may be taken into account that the person making the representation or the person's employer or principal knows or ought to know: that the consumer is unable to receive a substantial benefit from the subject-matter of the representation;
Regulations (Section 93)	The Cabinet Secretary shall make regulations for carrying out the purposes of the Act. Without prejudice to the generality of subsection (1), the regulations made under this section shall prescribe anything that is required to be prescribed under this Act.

A3.1.2 Kenya Information and Communications (Consumer Protection) Regulations 2010

The Kenya Information and Communications (Consumer Protection) Regulations 2010 (2) are made under the parent statute Kenya Information and Communications Act (3), legislation passed to, inter alia, "facilitate the development of the information and communications sector (including broadcasting, multimedia, telecommunications and postal services) and electronic commerce…" The regulations may apply to controlling the marketing of unhealthy foods to children.

Box A3.2

RELEVANT MARKETING PROVISIONS OF THE KENYA INFORMATION AND COMMUNICATIONS (CONSUMER PROTECTION) REGULATIONS 2010

Title	Relevant provision
Definition: Child (Regulation 2)	Any human being under the age of eighteen years
Protection of Children (Regulation 9)	Protection of children. (1) A licensee shall establish mechanisms that enable parents and legal guardians to block access of children to harmful content. (2) A licensee who owns promotes, glamorises or markets alcohol and tobacco products or other harmful substances that are directed at children commits an offence.

A3.1.3 Competition Act 2010

The Competition Act 2010 contains provisions for promoting and safeguarding competition in the national economy, and protecting consumers from unfair and misleading market conduct. Part VI of the Act relates to consumer welfare, although the emphasis is on unfair enterprise tactics that influence consumer behaviour (4). The enforcing body established under the Act, the Competition Authority of Kenya, has interpreted the mandate of its Consumer Protection Department broadly as being to "investigate complaints relating to false or misleading representations, unconscionable conduct as well as supply of unsafe, defective and unsuitable goods" (5). Based on this rendition, the authority can determine placement of goods based on suitability; this broad interpretation implies that the authority envisages a role for itself in relation to suitability of goods placed in the market. This interpretation is also buttressed by the clear provisions of Article 46 of the Constitution, which defines the rights of consumers as including the right to goods and services of reasonable quality; the information necessary for them to gain full benefit from goods and services; the protection of their health, safety and economic interests; and compensation for loss or injury arising from defects in goods or services. Where a product violates set safety standards, the power of the authority may be invoked accordingly, at least for the purposes of investigation of whether the product goes against a legally prescribed safety standard.

A3.1.4 Food, Drugs and Chemical Substances Act 1992

The Food, Drugs and Chemical Substances Act 1992 has marketing provisions relevant to the prevention and control of NCDs (6).

Box A3.3

RELEVANT MARKETING PROVISIONS OF THE FOOD, DRUGS AND CHEMICAL SUBSTANCES ACT

Title	Relevant provision
Definition Advertisement (Section 2)	"Advertisement" includes any representation by any means whatsoever for the purpose of promoting directly or indirectly the sale or disposal of any food, drug, cosmetic, device or chemical substance
Prohibition against sale of unwholesome, poisonous or adulterated food (Section 3)	Any person who sells any food that— (a) has in or upon it any poisonous or harmful substance; or (b) is unwholesome or unfit for human consumption; or (c) consists in whole or in part of any filthy, putrid, disgusting, rotten, decomposed or diseased substance or foreign matter; or (d) is adulterated, shall be guilty of an offence.

A3.2 Regulation of nutrition labelling and product formulation

A3.2.1 Food, Drugs and Chemical Substances Act 1992

The Food, Drugs and Chemical Substances Act 1992 seeks the "prevention of adulteration of food, drugs and chemical substances"; it also prohibits misrepresentation of foods being sold (6).

Box A3.4

RELEVANT MARKETING PROVISIONS OF THE FOOD, DRUGS AND CHEMICAL SUBSTANCES ACT

Title	Relevant provision
Definition Label (Section 2)	"Label" includes any legend, work or mark attached to, included in, belonging to or accompanying any food, drug, cosmetic, device or chemical substance
The offence of deception (Section 4)	Any person who labels, packages, treats, processes, sells or advertises any food in contravention of any regulations made under this Act, or in a manner that is false, misleading or deceptive as regards its character, nature, value, substance, quality, composition, merit or safety, shall be guilty of an offence
Standards of foods (Section 5)	Where a standard has been prescribed for any food, any person who labels, packages, sells or advertises any food which does not comply with that standard, in such a manner that it is likely to be mistaken for food of the prescribed standard, shall be guilty of an offence

A3.2.2 Food, Drugs and Chemical Substances (Food Labelling, Additives and Standards) Regulations 1978

The Food, Drugs and Chemical Substances (Food Labelling, Additives and Standards) Regulations 1978 (7) are made under the Food, Drugs and Chemical Substances Act (6). They provide for food labelling requirements that can be applied to enforce standards on product formulation or reformulation.

Box A3.5

REGULATIONS RELEVANT TO LABELING

Title	Relevant provision
Labelling, Special Dietary Foods and Policy (Reg 3)	No person shall sell a manufactured, processed or prepacked food, unless a label has been affixed or applied to that food.
Label applied to a food shall carry (Reg 4)	(a) On the main panel- (i) the brand or trade name of that food (if any); (ii) the common name of the food; (iii) in close proximity to the common name, a correct declaration of the net contents in terms of weight volume or number in accordance with the usual practice in describing the food; (b) grouped together on any panel- (i) a declaration by name of any preservatives used in the food; (ii) a declaration of permitted food colour added to the food; (iii) a declaration of any artificial or imitation flavouring preparation added to the food; (iv) in the case of a food consisting of more than one ingredient, a complete list of their acceptable common names in descending order of their proportions, unless the quantity of each ingredient is stated in terms of percentages or proportionate compositions; and (v) any other statement required under the provisions of these Regulations to be declared on the label; (c) on any panel, the name and address of the manufacturer, packer or distributor of the food.
Condition for describing food as sugarless, etc. (Reg 18)	For the purposes of these Regulations a food may be described as sugarless, sugar free, low in carbohydrates or by any other synonymous terms if it contains not more than 0.25 per cent glycogenic carbohydrates.
Sale of food containing non-nutritive sweetener (Reg 176)	No person shall sell any food to which a non-nutritive sweetener has been added except as prescribed by these Regulations.

Box A3.5 cont'd

REGULATIONS RELEVANT TO LABELING

Title	Relevant provision
Standard for, and labelling of, soft drinks (Reg 240)	(1) Soft drinks shall be the class of beverages made by absorbing carbon dioxide in potable water, the carbon dioxide being not less than that which will be absorbed by the beverage at a pressure of one atmosphere and at a temperature of 15.6° C, may contain optional ingredients and shall contain no ethyl alcohol or only such ethyl alcohol, not in excess of 0.5 per cent of the finished beverage, as is contributed by a flavouring ingredient used–. (2) The optional ingredients that may be used in soft drinks shall be- (a) nutritive sweeteners consisting of the dry or liquid form of sugar, invert sugar, dextrose, fructose, lactose, mannitol, honey, glucose syrup, sorbitol, or any combination of two or more of these; (b) flavouring preparations as prescribed in Part I; (c) food colours as prescribed for soft drinks in the Second Schedule; (d) one or more of the food additives prescribed for soft drinks in Tables IV, VIII, X and XI set out in the Second Schedule; (e) quinine in an amount not exceeding 83 parts per million by weight of the finished soft drinks; (f) in the case of canned soft drinks, stannous chloride in a quantity not exceeding 11 parts per million calculated as tin (Sn), with or without one or more of the other chemical preservatives prescribed in Table XI set out in the Second Schedule; (g) when one or more of the food additives prescribed for soft drinks in Table IV in the Second Schedule is used, dioctyl sodium sulfosuccinate as prescribed in that Schedule; (h) caffeine, in an amount not exceeding 0.02 per cent by weight of the finished beverage; and (i) sodium chloride, in an amount not exceeding 300 parts per million in the finished beverage. (3) The name of the soft drink which is neither flavoured nor sweetened shall be "soda water", "club soda" or "soda". (4) The name of each soft drink containing flavouring ingredients as specified in paragraph 2 (b) shall be "…… soda" or "…… soda water" or "…… carbonated beverage" or "…… soft drink", the blank being filled in with the word or words, such as "grape soda", that designate the characterizing flavour of the soft drink. (5) If the soft drink is one generally designated by a particular common name, such as "ginger ale" or "root beer", that name may be used in lieu of the name prescribed under paragraph (3) or (4). (6) For the purpose of paragraph (5), a proprietary name that is commonly used by the public as the designation of a particular kind of soft drink may likewise be used in lieu of the name prescribed under paragraph (3) or (4). (7) A soft drink containing such optional ingredient as caffeine, artificial flavouring, artificial colouring or any combination of these shall be labelled to show that fact by the label statement "with……." or "with…… added", the blank to be filled in with the word or words "caffeine", "artificial flavouring", "artificial colouring" or a combination of these words as appropriate. (8) If the soft drink contains one or more of the optional ingredients set forth in Table XI in the Second Schedule it shall be labelled to show that fact by one of the following statements, "..... added as a preservative" or "preserved with .....", the blank being filled in with the common name of the preservative as prescribed in the Second Schedule. (9) If the soft drink contains quinine salts the label shall bear a prominent declaration either by use of the word "quinine" in the name of the soft drink or by a separate declaration.

A3.2.3 Breast Milk Substitutes (Regulation and Control) Act 2012

The Breast Milk Substitutes (Regulation and Control) Act 2012 is intended to "provide for appropriate marketing and distribution of breast milk substitutes; to provide for safe and adequate nutrition for infants through the promotion of breastfeeding and proper use of breast milk substitutes, where necessary" (8). The Act codifies the International Code of Marketing of Breastmilk Substitutes, a voluntary code adopted by countries to help protect breastfeeding by setting standards for breastmilk substitutes, and to prevent commercial interests from overriding infant health needs (9). The Act prohibits the advertisement or promotion of food products described under the Act as "designated" and "complementary" food products.

Box A3.6

SUMMARY OF RELEVANT PROVISIONS UNDER THE BREAST MILK SUBSTITUTES (REGULATION AND CONTROL) ACT

Title	Relevant provision
Preamble	An Act of Parliament to provide for appropriate marketing and distribution of breast milk substitutes; to provide for safe and adequate nutrition for infants through the promotion of breastfeeding and proper use of breast milk substitutes
Definitions (section 2(1))	
Advertising	Means to make a representation by any means for the purposes of directly or indirectly promoting the sale or use of a designated or complementary food product, including— (a) written publication, a television or radio broadcast, film or electronic transmission, including the internet video or telephone; (b) displays, signs, symbols, colours, billboards or notices; or (c) exhibition of pictures or models
Breast milk substitute	Means any food that is marketed, or otherwise represented, as a partial or total replacement of breast milk, whether suitable for that purpose or not
Designated product **Complementary food product**	Means any food suitable or presented as a suitable complement to breast milk, for infants from the age of six months up to the age of twenty-four months
Designated product	Means— (a) any food or drink designed for infants marketed or otherwise represented to be a partial or total replacement of breast milk, whether or not it is suitable for that purpose; (b) feeding bottles; (c) teats; (d) infant formula; (e) follow-up formula for infants or children between the age of six months to twenty-four months; (f) products marketed or otherwise represented as being suitable for feeding infants of up to the age of six months; (g) breast milk fortifiers; (h) pacifiers; (i) cups with spout; or (j) any other product the Cabinet Secretary may, by a notice in the Gazette, declare to be a designated product
"infant"	Means a child from birth up to the age of twelve months

Box A3.6 cont'd

SUMMARY OF RELEVANT PROVISIONS UNDER THE BREAST MILK SUBSTITUTES (REGULATION AND CONTROL) ACT

Title	Relevant provision
"infant formula"	Means milk or a milk-like product of animal or plant origin, formulated industrially in accordance with the Codex Alimentarius Standard for Infant Formula, to satisfy the nutritional requirements of up to six months of age and includes all infant formula for special medical or nutritional purposes
"manufacturer"	Means a person or corporation or other entity, in public or private sector, engaged in the business of manufacturing a designated or complementary product, whether directly or through an agent, or a person controlled by or under an agreement with the manufacturer
"marketing"	Means any method of introducing or selling of a designated or complimentary product, and includes promotion, distribution, advertising, public relations, information services and distribution of samples
Committee and functions under the Act (Sections 3, 4 and 5)	The Act establishes a National Committee on Infant and Young Child Feeding for carrying out the following functions prescribed: (a) advise the Cabinet Secretary on the policy to be adopted in relation to infant and young child nutrition; (b) participate in the formulation of, and recommend the regulations to be made under this Act; and (c) perform any other functions as may, from time to time, be assigned by the Cabinet Secretary. The 13 Member committee is chaired by the Director of Public Health. Other Members include, the Director of Nutrition and Dietetic Services, the Director of the Kenya Bureau of Standards or his representative, the Director of the Kenya Medical Research Institute or his representative, the Chairperson of the Kenya Paediatric Association or his representative, the Chairperson of an institution representing nutritionists or his representative, a representative from private health institutions, a representative from non-governmental organizations with national mandate on infant and young child feeding, a representative of the Principal Secretary in the Ministry for the time being responsible for matters relating to trade, and two members with relevant expertise in infant and young child feeding appointed by the Cabinet Secretary.
Designated product **Complementary food product**	Means any food suitable or presented as a suitable complement to breast milk, for infants from the age of six months up to the age of twenty-four months

Box A3.6 cont'd

SUMMARY OF RELEVANT PROVISIONS UNDER THE BREAST MILK SUBSTITUTES (REGULATION AND CONTROL) ACT

Title	Relevant provision
Prohibition on advertisement and promotion (Section 6)	(1) A person shall not advertise or promote to the general public or cause to be advertised or promoted a designated or complementary food product. (2) For the purposes of this section, a person promotes a designated or complementary food product, where that person- (a) directly or indirectly introduces a designated or complementary food product or encourages the buying or use of the product; (b) uses sale devices such as special discounts, special displays to promote sales, competitions with prizes, tie-in sales, provision of premiums and rebates, discount coupons, loss leaders, giving of gifts and free samples of a designated or complementary food product to mothers; (c) as a marketer, makes a direct or indirect contact with members of the public in furtherance of, or for the purpose of promoting business of a designated or complementary food product; (d) makes electronic communications of a designated or complementary food product including internet, website and electronic mail; (e) distributes promotional items including clothing, stationery, household utensils or items that refer to a designated or complementary food product or the brand name of the product; (f) engages in any practices or communication in any form which create, or may create, any association with a designated or complementary food product; (g) publishes or causes to be published an advertisement of a designated or complementary food product; (h) distributes any information or educational material relating to infant and child feeding; (i) distributes or causes to be distributed, or donates or causes to be donated, or sells or causes to be sold a designated or complementary food product to charitable children's' institutions or a health facility; (j) engages persons whose duties involve marketing of a designated or complementary food product— (i) on remuneration which varies according to the volume of sale of designated or complementary food product; or (ii) for bonuses or similar incentives calculated directly according to the volume of sales of the designated or complementary food product; (k) displays to the public, material which refers directly or indirectly to a designated or complementary food product; (l) distributes materials to health workers which directly or indirectly refer to a designated or complementary food product; (m) offers a gift or a benefit or inducement including a fellowship, study grant, funding for attendance of meetings, seminars, continuing education or conferences to a health worker or a member of his family; (n) directly or indirectly provides any support, financial or otherwise to the general public or a health worker for the purposes of promoting a designated or complementary food product; (o) funds any research carried out by a health worker in infant and young child health; (p) employs a person to provide to health workers in health care facilities, pregnant women or mothers of infants and young children or any other person, with education or instructions regarding infant and young child health; or (q) sponsors, an event, contest, telephone counselling line or campaign aimed at pregnant women, mothers of infants or their families.

Box A3.6 cont'd

SUMMARY OF RELEVANT PROVISIONS UNDER THE BREAST MILK SUBSTITUTES (REGULATION AND CONTROL) ACT

Title	Relevant provision
Labelling of packages (Section 9)	The package of a designated or complementary food product shall contain notices, warnings and necessary information with respect to promotion of breastfeeding and proper use of breast milk substitutes in the wording, size and manner prescribed by the Cabinet Secretary.
Enforcement (Part IV of the Act)	The Cabinet Secretary has the power to appoint officers (authorised officers) for the purposes of enforcement of this Act.
Regulations and Orders (part V)	The Cabinet Secretary has power to make regulations and orders for the better enforcement of the provisions of the Act.

A3.2.4 Health Act 2017

The Health Act 2017 is a broad piece of legislation that is intended to "establish a unified health system, to coordinate the inter-relationship between the national government and county government health systems, to provide for regulation of health care service and health care service providers, health products and health technologies" (10). It contains provisions that can be expansively interpreted to facilitate the promotion of health generally and, more specifically, healthy diets, through stipulations on nutrition and physical activity. In its objects, the Act binds the Government of Kenya (at the national and county levels) to set up a health system that will facilitate the realization of the right to health. In the context of healthy diets, it not only guarantees the right of the child to basic nutrition, but also requires the national government to develop relevant policy guidelines and standards for human food consumption, dietetic services and healthy lifestyle. In addition, the national government is obliged to implement policies meant to reduce the burden of diseases, including those related to NCDs. Once created, these policies are to be implemented by county governments.

Box A3.7

IMPLICATIONS OF THE HEALTH ACT

Title	Relevant provision
Objects of the Act (Section 3)	The objects of the Act are to: • establish a national health system which encompasses public and private institutions and providers of health services at the national and county levels and facilitate in a progressive and equitable manner, the highest attainable standard of health services; • protect, respect, promote and fulfill the health rights of all persons in Kenya to the progressive realization of their right to the highest attainable standard of health • protect, respect, promote and fulfill the rights of children to basic nutrition and health care services contemplated in Articles 43(1) (c) and 53(1) (c) of the Constitution; • recognize the role of health regulatory bodies established under any written law and to distinguish their regulatory role from the policy making function of the national government.
Standard of health (Section 5)	Every person has the right to the highest standard attainable standard of health which shall include progressive access for provision of promotive, preventive, curative, palliative and rehabilitative services.
Part VII: Regulation of health products and health technologies (Section 62) **Functions of regulatory body (Section 63)**	There shall be established by an Act of Parliament a single regulatory body for regulation of health products and health technologies. (1) The regulatory body shall: (a) licence health products and health technologies; [...] (2) The classes of products governed by legislation shall extend to therapeutic feeds and nutritional formulations

References for Annex 3

1 Consumer Protection Act, 2012: Kenya Gazette Supplement No. 201 (Acts No. 46) Nairobi: Republic of Kenya; 2012 (http://www.parliament.go.ke/sites/default/files/2017-05/ConsumerProtectionActNo46of2012.pdf).

2 The Kenya Information and Communications (Consumer Protection) Regulations, Kenya 2010 (https://www.ca.go.ke/document/consumer-protection-regulations-2010/).

3 Kenya Information and Communications Act, Chapter 411A. [Rev. 2012], Kenya. 1998 (http://kenyalaw.org/kl/fileadmin/pdfdownloads/Acts/KenyaInformationandCommunicationsAct(No2of1998).pdf).

4 The Competition Act, Kenya. 2010 (https://wipolex.wipo.int/en/legislation/details/11301).

5 Competition Authority of Kenya. Consumer protection: overview. (https://www.cak.go.ke/what-we-do/consumer-protection/overview).

6 Food, Drugs and Chemical Substance Act, Kenya. 1992 (https://infotradekenya.go.ke/media/Foods%20Drugs%20and%20Chemical%20Substances%20Act.pdf).

7 Food, Drugs and Chemical Substances (Food Labelling, Additives and Standards) Regulations. 1978 (http://extwprlegs1.fao.org/docs/pdf/ken62536.pdf).

8 Breast Milk Substitutes (Regulation and Control) Act (No. 34 of 2012). Kenya: Kenyan Parliament; 2012 (http://kenyalaw.org:8181/exist/kenyalex/actview.xql?actid=No.%2034%20of%202012).

9 International Code of Marketing of Breast-milk Substitutes. Geneva: World Health Organization; 1981 (https://www.who.int/nutrition/publications/code_english.pdf).

10 The Health Act, Act No.21 of 2017. Kenya: Kenya gazette supplement,; 2017 (http://kenyalaw.org/kl/fileadmin/pdfdownloads/Acts/HealthActNo.21of2017.pdf).

ANNEX 4: Tanzania – regulation of marketing and labelling of food products, and promotion of physical activity

A4.1 Regulation of marketing and labelling of food products

A4.1.1 The Tanzania Standards Act 2019

In 2019 the provisions in the Tanzania Food, Drugs and Cosmetics Act 2003 relating to food and food safety were transferred to the Tanzania Standards Act 2019 and related responsibility assigned to the Tanzania Bureau of Standards by Part VIII of the Finance Act, No. 8 of 2019 (1). These changes were confirmed by the Tanzania Bureau of Statistics vide notice (in Swahili).[1]

Box A4.1

SUMMARY OF PROVISIONS ON THE REGULATION OF FOOD IN TANZANIA STANDARDS ACT, AS AMENDED IN 2019

Title	Relevant provision
Definitions (Section 2)	
Food	Any substance whether processed, semi-processed or raw which is intended for human consumption, and includes drinks, chewing gum and any substance which has been used in the manufacture, preparation or treatment of food but does not include cosmetics, tobacco or substance used only as drugs
Label	Any tag, brand, mark, pictorial or other descriptive matter, written, printed, stencilled, marked, embossed or impressed on or attached to a container of any food or cosmetic
Package	Any product regulated under this Act, means any box, packet or any other article in which one or more primary containers of products regulated under this Act are to be enclosed in one or more other boxes, packets or articles in question […]
Provisions regarding pre-packaged food	• No person shall manufacture, import, distribute, sell or expose for sale pre-packaged food unless that food or food product has been registered by the Bureau (Section 21A(1)) […] The Bureau shall register any pre-packaging food or food product if it is satisfied that, the food or food product complies with prescribed standards and the manufacturing operations for such food complies with the prescribed current Good Manufacturing Practice requirements. (Section 21A(3))
Regulations (Section 36)	[The Minister may make rules on…] (e) matters related or connected with premises registration or registration of food, food products or cosmetics...

[1] See https://finandlaw.co.tz/wp-content/uploads/2020/10/TBS-and-TFDA-Merger.pdf

A4.1.2 The Tanzania Food, Drugs and Cosmetics (Control of Food Promotion) Regulations 2010

The Tanzania Food, Drugs and Cosmetics (Control of Food Promotion) Regulations 2010 (2), made under the Tanzania Food, Drugs and Cosmetics Act 2003 (3), provide rules with respect to "food promotion" and bar false or misleading representations regarding food. Any promotion needs to be authorized by the Tanzania Food and Drugs Authority. The regulations cover nutritional claims on foods, including "special food" and baby food.

Box A4.2

SUMMARY OF THE RELEVANT PROVISIONS IN THE TANZANIA FOOD, DRUGS AND COSMETICS (CONTROL OF FOOD PROMOTION) REGULATIONS 2010

Title	Relevant provision
Definition clause (Regulation 2)	
Food promotion	Means any method of introducing, familiarizing or encouraging a person to use a particular food product
Health claim	Means any representation that states, suggests or implies that a relationship exists between a food category, a food or one of its constituents and health, including nutrient function claims and reduction of disease risk claims
Label	Means any tag, brand, mark, pictorial or other descriptive matter, written, printed, stencilled, marked, embossed, or impressed on or attached to a container of any food product
Nutrient claim	Means any claim which states, suggests or implies that a food has particular nutrition properties due to: (a) the energy (calorific value) it provides. provides at a reduced or increased rate or does not provide, and or (b) the nutrients or other substances it contains, contains in reduced or increased proportions or does not contain
Promotion (Part II)	• A person shall not promote any food product in a manner that is false, misleading or deceptive (Reg. 3(1)) • No promotional material shall be used unless approved from the Authority under the TFDA Act

Box A4.2 cont'd

SUMMARY OF THE RELEVANT PROVISIONS IN THE TANZANIA FOOD, DRUGS AND COSMETICS (CONTROL OF FOOD PROMOTION) REGULATIONS 2010

Title	Relevant provision
Prohibited claims (Regulation 4)	(1) The following claims whether represented in words, pictorial representations, marks or any description are prohibited: (a) claims which make reference to general, non-specific benefits of the nutrient or food for overall good health or well-being… (c) claims which make reference to slimming or weight control…; (g) claims stating that any given food will provide an adequate source of all essential nutrients, except in the case of well-defined products accepted by the Authority (2) Health claims shall only be allowed if: (a) accompanied by the information which is truthful and non-misleading to help consumers choose healthy diets; (b) accompanied by a statement indicating the importance of a balanced diet and a healthy lifestyle; (c) show the quality of the food and patterns of consumption required to obtain the claimed beneficial effect; (d) accompanied by an appropriate statement addressed to persons who should avoid using the food (e) accompanied by a warning not to exceed quantities of the product that may represent a risk to health
Use of specific terms (regulation 5)	(1) The words "health" or "healthy" or other words or symbols implying that the food has health giving properties, or "wholesome" or "nutritious" shall not be used as part of the name or description of the food...
Offences and penalty (Part III)	Any person who contravenes any provision of these regulations or requirements indicated in these regulations commits an offence and is liable to: if an individual, a fine not less than one thousand shillings or to imprisonment for a term not less than two weeks or to both; if a body corporate or association, a fine of not less than one million shillings (Regulation 9)

A4.1.3 The Tanzania Food, Drugs and Cosmetics (Food Labelling) Regulations 2006

The Tanzania Food, Drugs and Cosmetics (Food Labelling) Regulations 2006 have been made under the Food, Drugs and Cosmetics Act to provide for labelling of foods (4).

A4.1.4 The Tanzania Food, Drugs and Cosmetics (Marketing of Foods and Designated Products for Infants and Young Children)

Box A4.3

SUMMARY OF APPLICABLE PROVISIONS IN THE TANZANIA FOOD, DRUGS AND COSMETICS (FOOD LABELLING) REGULATIONS 2006

Title	Relevant provision
Declarations to be included on food labels (Regulation 5)	The label applied to a food shall carry, inter alia, on the main panel: (i) the brand or trade name of that food; (ii) the common name of the food; (iii) the net contents in terms of weight, volume or number in accordance with the usual practices.
Declaration of artificial sweeteners (Regulation 13)	A food containing non-nutritive sweetener shall carry on the label a statement to the effect that it contains such artificial sweeteners by naming the synthetic sweetener.

Regulations 2013

The Tanzania Food, Drugs and Cosmetics (Marketing of Foods and Designated Products for Infants and Young Children) Regulations 2013 control the marketing of foods and designated products for infants and young children (5). The regulations incorporate principles in the 1981 International Code on Marketing of Breast-milk Substitutes (6).

A4.1.5 Tanzania Food, Drugs and Cosmetics (Food Fortification) Regulations 2011

Box A4.4

SUMMARY OF APPLICABLE PROVISIONS IN THE TANZANIA FOOD, DRUGS AND COSMETICS (MARKETING OF FOODS AND DESIGNATED PRODUCTS FOR INFANTS AND YOUNG CHILDREN) REGULATIONS 2013

Title	Relevant provision
Definition clause (Regulation 3)	
Infant	A person not more than twelve months of age
Marketing	Any method of introducing or selling a breast-milk substitute, complementary food or designated product including promotion, distribution, advertising, display on shelves, production, distribution of samples, product public relations and product informational services
Prohibited promotional practice	(a) special displays of or concerning a breast-milk substitute, complementary food or designated product discount coupons; (b) "tie-in sales"; (c) the selling of a breast-milk substitute, complementary food or designated product at a reduced price unless such reduction in price is intended to be permanent; (d) the distribution of gifts or items of little or no cost bearing the name or logo of a manufacturer or distributor; (e) the use of printed matter including books, pamphlets, or posters bearing the name, logo, graphic or other representation of a proprietary product or the name or logo of a manufacturer or distributor; (f) promotional practice in any other manner
Young child	A person from the age of more than 12 months up to the age of five years
Education and health care facilities (Part II)	Any informational or educational material related to infant or young child nutrition shall be submitted to the Authority for approval before being distributed of intended use (Reg. 4(1))
Product composition, safety, quality and labelling (Part IV)	General, safety, quality and essential composition requirement for infant formula, follow up formula, formula for special medical purposes intended for infants and complementary food shall be in accordance with national standard or in case there is no national standard, international standard

The Tanzania Food, Drugs and Cosmetics (Food Fortification) Regulations 2011 are also made under the Food, Drugs and Cosmetics Act and provide for labelling of foods whose nutrient composition has been altered through fortification (7). They set requirements for licensing of manufacture, sale and import of fortified foods.

A4.1.6 Zanzibar Food, Drugs and Cosmetics Act 2006

Box A4.5

SUMMARY OF APPLICABLE PROVISIONS IN THE TANZANIA FOOD, DRUGS AND COSMETICS (FOOD FORTIFICATION) REGULATIONS 2011

Title	Relevant provision
Definition clause (Regulation 2)	
Fortification	The addition of one or more micronutrient(s) to food for the purpose of preventing or correcting a deficiency of one or more micronutrients(s) in the population or in a specific group of the population
Label	A tag, brand, mark, pictorial, or other descriptive matter, written, printed, stencilled, marked, embossed, or impressed on or attached to a container of any food product
Micronutrient	A natural or synthesized vitamin, mineral, or trace element that is essential for normal growth, development and maintenance of health
Package	Any box, packet or any other article in which one or more primary containers of products are to be enclosed
Authority to amend the Schedules (Regulation 4)	The Minister of Health has the power to vary, amend or revoke any schedule prescribed in the Regulations
Labelling	In addition to the labelling requirements set by the Tanzania Food, Drugs and Cosmetics (Food Labelling) regulations in force, fortified food shall be conspicuously labelled including the following; (a) the word fortified immediately prior to or after the common name of the food (b) specific name and amount of each micronutrient added into the food, in milligram per kilogram in case of solids or milligram per litre in case of liquids (c) the label for fortified food shall bear food fortification logo as prescribed in the third schedule to these regulations

The Zanzibar Food, Drugs and Cosmetics Act 2006 provides for the comprehensive regulation and control of food (defined as any article other than drugs, cosmetics and tobacco used as food or drink for human consumption and includes any substance used in manufacture or treatment of food), drugs, medical devices, cosmetics, herbal drugs and poisons (8). It is administered by the Zanzibar Food, Drugs and Cosmetics Board and the Zanzibar Food and Drug Agency.

A4.1.7 Standards Act 2009

Box A4.6

RELEVANT PROVISIONS IN THE ZANZIBAR FOOD, DRUGS AND COSMETICS ACT 2006

Title	Relevant provision
Section 4 Functions of the Zanzibar Food, Drugs and Cosmetics Board (FDCB)	
Section 12 Establishment of Technical Committees and provide for their functions	The addition of one or more micronutrient(s) to food for the purpose of preventing or correcting a deficiency of one or more micronutrients(s) in the population or in a specific group of the population
Section 13 Establishment of Zanzibar Food and Drugs Laboratory	A tag, brand, mark, pictorial, or other descriptive matter, written, printed, stencilled, marked, embossed, or impressed on or attached to a container of any food product
PART III PROVISION REGARDING FOOD	
Section 26 Pre-packaged food	26.(1) No person shall manufacture, import, distribute, sell or expose for sale pre-packaged food unless that food or food product has been registered or approved by the Board.
Section 27 Regulations regarding the composition of food	27.(1) The Minister may, after consultation with the Board, make regulations prescribing standards to be complied with by manufacturers with regard to the composition of food or its microbiological or chemical or physical standards. (2) Without prejudice to the generality of the power conferred by subsection (1) of this section, the Minister may in those regulations: (c) prohibit or regulate the importation of any food which, in his opinion, is or may be prejudicial to public health

Box A4.6 cont'd

RELEVANT PROVISIONS IN THE ZANZIBAR FOOD, DRUGS AND COSMETICS ACT 2006

Title	Relevant provision
PART VI PACKAGING AND LABELLING **Labeling of products regulated under this Act**	93. (1) No person shall, in the course of a business operated by him, sell or supply or have in his possession for purposes of selling or supplying any product regulated under this Act in a container or package which is not labeled in accordance with the regulations made under section 123 of this Act.
PART V11 PROMOTION	96. The Minister on advice of the Board, may make regulations to regulate any promotional activities connected to food, drugs, medical devices or herbal drugs. 99. (1) No person shall advertise any product regulated under this Act in a manner that is false, misleading or deceptive or is likely to create erroneous impression regarding its character, value, quantity, composition, merit, safety or efficacy as the case may be. (2) No person shall carry out any promotion activities on products regulated under this Act, except and after getting a written approval from the Board.
Section 123 – Regulations	123. (1) The Minister on advice of the Board may make regulations for better carrying of and with respect to any of the following matters or for any of the following purposes: … (c) providing for the better regulation of the manufacture, compounding, sell or advertising of foods, drugs, medical device, herbal drug and poisons; (e) the regulation of the manufacture, importation, exportation, distribution and labeling of food, drugs, device, herbal medicines, biologicals and vaccines cosmetics and poisons; (f) the regulation of the prices of both manufactured and imported food, drugs, medical devices, herbal drug and poisons; (g) regulating of containers or packaging material in which food, medical device, herbal drug or poison may be contained; (l) provide regulations for registration of food, drugs, medical devices and herbal drugs

The Standards Act 2009 provides for standardization and quality control of products. It establishes the Tanzania Bureau of Standards and grants it the mandate to implement measures for quality control of products of all descriptions, and promote standardization in industry and commerce (9). This is relevant for regulating the quality and content of food and NABs for the purposes of health protection, and many of its provisions may be so applied.

Box A4.7

RELEVANT PROVISIONS OF THE STANDARDS ACT 2009

Title	Relevant provision
Preamble	An Act to provide for the promotion of the standardization of specifications of commodities and services, to re-establish the Tanzania Bureau of Standards.
Definition clause (Section 2)	
Commodity	Means an article or thing which is the subject of industry, trade or business.
Specification	Means a description of any commodity by reference to its nature, quality, strength, purity, composition, quantity, dimensions, weight, grade, durability, origin, age or other characteristics or to any substance or material of or with which, or the manner in which, any commodity may be manufactured, produced, processed or treated.
Tanzania Bureau of Standards (Part II)	Under the Act, the Bureau is set out as the custodian and overseer of observance of standards in Tanzania. Inter alia, the Bureau is responsible for assisting the Government or any other person in the preparation and framing of standards. In the performance of its functions the Bureau shall: (a) have regard to the health, safety, environment and general welfare of the people of the United Republic; and (b) maintain, as far as may be practicable, a system of consultation and co-operation with anybody established by or under any written law and having functions similar to those specified in subsection (I) or having
Management of the Bureau	The management and control of the Bureau shall vest in the Board. The Director General of the Bureau (appointed by the President) shall be the Chief Executive of the Bureau and Secretary to the Board. The Director General is also responsible for forming the technical committees charged with formulation of universally applicable standards in various sectors of the economy.
Establishment of standards (Part IV)	The Minister of Industries and Trade may on the recommendation of the Bureau and subject to the provisions of subsections (2) and (3), declare any mark which has been approved by the Bureau in respect of any standard prescribed or recognized by the Bureau for any commodity or the manufacturing, production, processing or treatment of any commodity, to be a standards mark in respect of it and may, in like manner, cancel or amend that mark.
Enforcement provisions (Part V)	The Minister may, at the request of the Board appoint any public officer or officer of the Bureau as an Inspector for the purposes of the Act. The Inspector would be empowered to enter any premises to inspect and take samples of any commodity or inspect any process in connection with the manufacturing, production, processing or treatment of any commodity.

A4.1.8 The Fair Competition Act 2003

The Fair Competition Act 2003 seeks to promote and protect effective competition in trade and commerce, and to protect consumers from unfair and misleading market conduct (10).

Box A4.8

SUMMARY OF RELEVANT PROVISIONS IN THE FAIR COMPENSATION ACT 2003

Title	Relevant provision
Definition clause (Section 2) Consumer	Any person who purchases or offers to purchase goods or services otherwise than for the purpose of resale but does not include a person who purchases any goods or services for the purpose of using them in the production or manufacture of any goods or articles for sale.
Misleading and deceptive conduct (Part III)	No person shall, in connection with supply or possible supply of good or services or in connection with the promotion by any means of the supply or use of goods or services: [...] (j) make a false or misleading representation concerning the need for any goods (Section 16)

A4.1.9 The Electronic and Postal Communications Act 2010

The Electronic and Postal Communications Act 2010 seeks to, among other aims, "provide for a comprehensive regulatory regime for electronic communications service providers and postal communications service providers" and "provide for duties of electronic communications and postal licensees, agents and customers, content regulation, issuance of postal communication licences and to regulate competitions and practices" (11). It grants implementing power to the Tanzania Communications Regulatory Authority, which can use those powers to regulate dissemination of communication on foods and non-alcoholic drinks to meet the policy requirements on preventing and controlling NCDs.

Box A4.9

SUMMARY OF RELEVANT PROVISIONS IN THE ELECTRONIC AND POSTAL COMMUNICATIONS ACT 2010

Title	Relevant provision
Definition clause (Section 3)	
Authority	Means the Tanzania Communications Regulatory Authority established under Tanzania Communications Regulatory Authority Act
Content	Means information in the form of speech or other sound, data, text or images whether still or moving, except where transmitted in private communications
Regulation of content (Section 103, 104 & 105)	All content service licensees shall be bound to observe the Code of Conduct contemplated under the Act. The Conduct shall be designed to achieve the protection of children.

A4.1.10 The Electronic and Postal Communications (Radio and Television Broadcasting Content) Regulations 2018

The Electronic and Postal Communications (Radio and Television Broadcasting Content) Regulations 2018 are made under the Electronic and Postal Communications Act and are applied "in relation to broadcasting content services on any platform" in mainland Tanzania (12). Its provisions may be used to regulate marketing communication on food and drinks, notably if considered as negative influences on, or unsuitable for, children.

Box A4.10
SUMMARY OF RELEVANT PROVISIONS IN THE ELECTRONIC AND POSTAL COMMUNICATIONS (RADIO AND TELEVISION BROADCASTING CONTENT) REGULATIONS 2018

Title	Relevant provision
Definition clause (Section 3) Child	Means persons below the age of eighteen years
Protection of children (Section 12)	A content services licensee shall- (a) ensure that due care is exercised in order to avoid content which may disturb or be harmful to children; (b) not broadcast programmes as referred to in paragraph (a) during family viewing of listening period; (c) request permission to conduct interviews with minors from the minor's parents or guardians before conducting an interview with a minor; (d) protect children from negative influences
Advertisement (Section 20)	A licensee shall exercise responsible judgment when scheduling advertisement which may be unsuitable for children during period when large numbers of children may be expected to be watching or listening to programmes

A4.2 Promotion of physical activity

A4.2.1 The Urban Planning Act 2007

Section 9 of this act describes a "general planning scheme". The purpose of such a scheme is "to coordinate sustainable development of the area to which it relates in order to promote health, safety, good order, amenity, convenience and general welfare of such area as well as efficiency and economy in the process of such development" (s.(1)). Specifically, the purpose "shall be to improve the land and provide for the proper physical development of such land, and to secure suitable provision for transportation, public purposes, utilities and services, commercial, industrial, residential and recreational areas, including parks, open spaces, agriculture and reserves and for the making of suitable provision for the use of land for building or other purposes" (13).

A4.2.2 The National Education Act 1978

National education is defined in the National Education Act 1978 (14) as "the instruction or training of persons of all ages in various fields of learning designed to contribute to the spiritual, moral, mental and physical development of the community, and to the attainment of the wider national goals of ujamaa and self-reliance". This broad definition may accommodate education programmes that promote physical health.

A4.2.3 National Sports Council of Tanzania Act 1967

The National Sports Council of Tanzania Act 1967 sets up a Council charged with the function of developing, promoting and controlling all forms of amateur sports on a national basis, in conjunction with voluntary amateur sports organizations or associations (15). The Council provides training and other staff; grants-in-aid to national associations or organizations; stadia, playing fields and other facilities; and sports equipment and other sports items as may be necessary for the accelerated development of sports. The Council is also mandated to stimulate general interest in all sports at all levels.

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14 The National Education Act, United Republic of Tanzania. 1978 (http://www.unesco.org/education/edurights/media/docs/873ae01bc28cf449895950c7cac2a419d3ede5fd.pdf).

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ANNEX 5: Uganda – regulation of marketing and labelling, institutional structure and physical activity

A5.1 Regulation of marketing and labelling

A5.1.1 Food and Drugs Act 1959

The Food and Drugs Act 1959 (1) seeks to make provisions for the prevention of adulteration of food and drugs and for incidental and connected matters. Relevant provisions are distilled in Box 5.1.

Box 5.1

RELEVANT PROVISIONS OF THE FOOD AND DRUGS ACT 1959

Title	Relevant provision
Definition clause (Section 1)	
Advertisement	Includes any notice, circular, label, wrapper, invoice or other document, and any public announcement made orally or by any means of producing or transmitting light or sound, and "advertise" shall be construed accordingly
Business	Includes the undertaking of a canteen, club, school, hospital or institution whether carried on for profit or not, and any undertaking or activity carried on by a local authority
Food	Includes drink, chewing gum and other products of a like nature and use, and articles and substances used as ingredients in the preparation of food or drink or of such products, but does not include— (i) water, live animals or birds; (ii) fodder or feeding stuffs for animals, birds or fish; or (iii) articles or substances used only as drugs
Relevant provisions on labelling of food and drugs (Section 5)	(1) A person who gives with any food or drug sold by him or her, or displays with any food or drug exposed by him or her for sale, a label whether attached to or printed on the wrapper or container or not, which— (a) falsely describes the food or drug; or (b) is calculated to mislead as to its nature, substance or quality, commits an offence, unless he or she proves that he or she did not know, and could not with reasonable diligence have ascertained, that the label was of such a character as aforesaid, and is liable on conviction to a fine not exceeding two thousand shillings.
Examination and seizure of suspected food (Section 7)	An authorised officer may at all reasonable times examine any food intended for human consumption which has been sold, or is offered or exposed for sale or is in the possession of, or has been deposited with or consigned to, any person for the purpose of sale or of preparation for sale, and if it appears to him or her to be unfit for human consumption, may seize it and remove it in order to have it dealt with by a magistrate.
Administration under the Act Enforcement provisions	There is no implementing body set up under the Act, but the Minister may authorise an officer for enforcement purposes.
Enforcement provisions	An authorised officer under the Act has the power to enter premises (Section 24); power to enter ships, trains, aircraft, vehicles, etc. (Section 25); and prohibit the sale of imported food (Section 26).
Regulations (Section 41)	The Minister may make regulations for: - imposing requirements as to and otherwise regulating the labelling, marking or advertising of food intended for sale for human consumption, and the descriptions which may be applied to such food.

A5.1.2 Uganda Communications Act 2013

The Uganda Communications Act 2013 (2) provides for regulation of communications in Uganda, and establishes the Uganda Communications Commission as the regulatory body.

Box 5.2

UGANDA COMMUNICATIONS ACT 2013

Title	Relevant provision
Preamble	An Act to consolidate and harmonise the Uganda Communications Act and the Electronic Media Act; to dissolve the Uganda Communications Commission and the Broadcasting Council and reconstitute them as one body known as the Uganda Communications Commission; and to provide for related matters
Definition clause Electronic media (Section 2)	It means communication of any message to the public by means of any electronic apparatus
Implementing authority under the Act (Part II) Uganda Communication Commission	A body corporate established under the Act. The Commission is responsible for implementing the objectives of the Act, namely, to monitor, inspect, license, supervise, control and regulate communication services
Broadcasting standards relevant for children (Schedule 4)	A broadcaster or video operator shall ensure that— (a) any programme which is broadcast— (i) is not contrary to public morality; (ii) does not promote the culture of violence or ethnical prejudice among the public, especially the children and the youth; (iii) in the case of a news broadcast, is free from distortion of facts; (iv) is not likely to create public insecurity or violence; (v) is in compliance with the existing law

A5.1.3 Uganda Communications Commission Advertising Standards

The Uganda Communications Commission has issued Advertising Standards (3) to guide advertisers, agencies and media owners, and to ensure that advertising does not mislead, harm or offend. Regardless of the product, service or message being advertised, the principles apply to also ensure that advertisements are socially responsible. The applicable rules are summarized in Box 5.3.

Box 5.2

UGANDA COMMUNICATIONS ACT 2013

Title	Relevant provision
Preamble	The Standards were prepared by the Uganda Communications Commission working with media and advertising industry. The Standards contain wide-ranging rules designed to ensure that advertising does not mislead, harm or offend. Ads must also be socially responsible and prepared in line with the principles of fair competition.
General provisions	- The Standards shall be administered and enforced by the Uganda Communications Commission. - Advertisers (publicist and channels transmitting messages to the public), shall be bound by the code. The authority to interpret and pass judgment on matters relating to the Code shall be vested in the Commission in accordance with its mandate to regulate content under Section 5(x) of the Uganda Communications Act.
Definitions **Advertisement**	It shall mean any visual or oral communication, representation, reference or notification of any kind – (i) which is intended to promote the sale, leasing or use of any goods or services; or (ii) which appeals for or promotes the support of any cause. (iii) Promotional content of display material, menus, labels, and packaging shall also fall within the definition. Editorial material shall however not be an advertisement, unless it is editorial for which consideration has been given or received. (iv) The word "Advertisement" shall apply to published advertising wherever it may appear. It shall however not apply to editorial or programming publicity.
Children	Persons who are under the age of 18 years
Young people	Children between the ages of 13–17 years
Minors	Children below 13 years.
Consumer	Any person who is likely to be reached by or who is actually exposed to an advertisement. This includes an end consumer, user or trade customer.
Advertisements directed at children (Regulation 7)	Advertisements addressed to or likely to influence children shall not contain any statement or visual presentation which might result in harming them, mentally, morally, physically or emotionally. The aim of the general principle is that children shall not be brought under the impression that it is acceptable and safe to be in certain surroundings; and situations as indicated or produced in the advert where such advert displaying acceptable material under clause 4(b)(ii) & (iii). Particular attention and care shall be taken in advertisement that are aimed at or are likely to be viewed by Minors.
Sponsorship considerations for programme genres **Children's programmes**	Sponsorship of children's programmes should be treated with caution. Broadcasters should consider carefully the appropriateness of any sponsorship of children's programmes as children are unlikely to understand fully the relationship between sponsor and programme.
Annex 13: Standards pertaining to specific products and services **Alcohol**	Commercial communications for alcoholic drinks shall not be aimed at children or depict children consuming these beverages.

A5.1.4 Uganda National Bureau of Standards Act

The Uganda National Bureau of Standards Act (4) provides for the standardization of commodities and provides for specification of any commodity, process or practice as applied to goods, which includes food and food products. The Act establishes the Uganda National Bureau of Standards (UNBS) and sets out its functions. The UNBS is empowered to exercise jurisdiction over various aspects of food quality.

Box 5.4

APPLICABLE STANDARDISATION PROVISIONS IN THE UGANDA NATIONAL BUREAU OF STANDARDS ACT

Title	Relevant provision
Establishment of the UNBS-section 2	There is established a bureau to be known as the Uganda National Bureau of Standards
Functions of the UNBS-section 3	(a) formulate national standard specifications for commodities and codes of practice as may from time to time be required; (b) promote standardisation in commerce, industry, health, safety and social welfare; (c) determine, review, modify or amend standard specifications and codes of practice as may from time to time be required; (d) endorse or adopt any international or other country's specification with or without any modification as suitable for use in Uganda; (e) require certain products treatment or performance and to prohibit substandard goods where necessary; (f) enforce standards in the protection of the public against harmful ingredients, dangerous components, shoddy material and poor performance; (g) promote trade among African countries and the world at large through the harmonisation of standard specifications demanded in various countries; (h) provide for the testing of locally manufactured or imported commodities with a view to determining whether the commodities conform to the standard specification declared under this Act; (i) make arrangements or provide facilities for the examination, testing or analysis of commodities and any material or substance from which or with which and the manner in which they may be manufactured, produced, processed or treated; (j) make arrangements or provide facilities for the testing and calibration of precision instruments, gauges and scientific apparatus, for determining their degree of accuracy by comparing them with the devices approved by the Minister on the recommendation of the council and for the issue of certificates thereto; (k) assist the Government, a local administration, a statutory corporation, a company or any other person in the preparation or framing of any internal or company standard specification or in the preparation or framing of any internal or company code of practice; (l) provide for cooperation with the Government, representatives of any industry, commercial organisation, local administration, statutory corporation or any other person with a view to securing the adoption and practical application of standards; (m) encourage or undertake educational work in connection with standardisation; (n) procure the recognition of the bureau by any other country; (o) seek membership of any international organisation connected with standardisation; (p) develop and maintain a collection of materials relating to standardisation and related matters.

UNBS: Uganda National Bureau of Standards.

On the basis of the above mandate, the UNBS has established different codes that are directly applicable to food and NABs. Some relevant codes are shown in Box 5.5.

Box 5.5

APPLICABLE UNBS CODES

Uganda Standard US EAS 803 Nutrition labelling – Requirements	
Section/title	**Key provisions/text**
1. Purpose	To ensure that the nutrition labelling is effective in providing the consumer with information so that a wise choice of food can be made. Additionally, so that the nutrition labelling does not describe a product or present information about it in any false, misleading, deceptive or insignificant manner.
2. Relevant definitions	
"Nutrition declaration"	Standardized statement or listing of the nutrient content of a food.
"Nutritional claim"	Any representation which states, suggests or implies that a food has particular nutritional properties including but not limited to the energy value and to the content of protein, fat and carbohydrates, as well as the content of vitamins and minerals. The following do not constitute nutrition claims: (a) the mention of substances in the list of ingredients; (b) the mention of nutrients as a mandatory part of nutrition labelling; and (c) quantitative or qualitative declaration of certain nutrients or ingredients on the label.
"Nutrition labelling"	Description intended to inform the consumer of nutritional properties of a food and consists of two components: (a) nutrient declaration; and (b) supplementary nutrition information.
"Nutrient reference values" (NRVs)	Set of numerical values that are based on scientific data for purposes of nutrition labelling and relevant claims. They comprise of two types of NRVs: -nutrient reference values: requirements (NRVs-R) refer to NRVs that are based on levels of nutrients associated with nutrient requirements; and -nutrient reference values – non-communicable disease (NRVs-NCD) refer to NRVs that are based on levels of nutrients associated with the reduction in the risk of diet-related non-communicable diseases not including nutrient deficiency diseases or disorders.

Box 5.5 cont'd

APPLICABLE UNBS CODES

Uganda Standard US EAS 803 Nutrition labelling – Requirements	
Section/title	**Key provisions/text**
3. General principles for nutrition labelling	(i) The information for nutrient declaration supplied is for the purpose of providing consumers with a suitable profile of nutrients contained in the food and considered to be of nutritional importance. The information is meant only to convey an understanding of the quantity of nutrients contained in the product. There is no exact quantitative knowledge of what individuals should eat in order to maintain health. A more exact quantitative delineation for individuals is not valid because there is no meaningful way in which knowledge about individual requirements can be used in labelling. (ii) The content of supplementary nutrition information will vary from one target population group to another according to the national health policy and guidelines. Nutrition labelling should not deliberately imply that a food which carries such labelling has necessarily any nutritional advantage over a food which is not so labelled.
4. Nutrient declaration	(i) Shall be made for all pre-packaged food for which nutrition or health claims, as defined in the EAS 805; (ii) It shall be mandatory for a nutrient declaration to state: (a) energy value; (b) the amounts of protein, available carbohydrate, fat, saturated fat, sodium and total sugars; (iii) The amount of any other nutrient for which a nutrition claim is made The amount of any other nutrient considered to be relevant for maintaining a good nutritional status, as required by national legislation.
5. Presentation of nutrient content	(i) The declaration of nutrient content shall be numerical. Additional means of presentation may be used. (ii) Information on energy value shall be expressed in kilojoules and kilocalories per 100 grams or per 100 mililitres. In addition, this information may be given per serving as quantified on the label, per package if the package contains only a single portion or per portion provided that the number of portions contained in the package is stated. (iii) Information on the amounts of protein, carbohydrate and fat in the food shall be expressed in grams per 100 grams or per 100 mililitres. In addition, this information may be given per serving as quantified on the label, per package if the package contains only a single portion or per portion provided that the number of portions contained in the package is stated. Numerical information on vitamins and minerals shall be expressed in metric units and/or as a percentage of the NRV per 100 grams or per 100 millilitres or per package if the package contains only a single portion. In addition, this information may be given per serving as quantified on the label or per portion provided that the number of portions contained in the package is stated.

Box 5.5 cont'd

APPLICABLE UNBS CODES

Uganda Standard US EAS 805 Use of nutrition and health claims – Requirements	
Section/title	**Key provisions/text**
1. Relevant definitions	
"Nutrient content claim"	A claim that describes the level of a nutrient contained in a food e.g., "source calcium", "high in fibre low in fat"
"Non-addition claim"	Any claim that an ingredient has not been added to a food, either directly or indirectly. The ingredient is one whose presence or addition is permitted in the food and which consumers would normally expect to find in the food
"Health claim"	Any representation that states, suggests, or implies that a relationship exists between a food or a constituent of that food and health. Health claims include the following: • nutrient function claims: claims that describe the physiological role of the nutrient in growth, development and normal functions of the body • other function claims: claims that concern specific beneficial effects of the consumption of foods or their constituents, in the context of the total diet on normal functions or biological activities of the body. Such claims relate to a positive contribution to health or to the improvement of a function or to modifying or preserving health • reduction of disease risk claims: claims relating the consumption of a food or food constituent, in the context of the total diet, to the reduced risk of developing a disease or health-related condition
2. Nutrition labelling	Any food for which a nutrition or health claim is made shall be labelled with a nutrient declaration in accordance with EAS 803
3. Nutrition claims	(i) The only nutrition claims permitted shall be those relating to energy, protein, carbohydrate, and fat and components thereof, fibre, sodium and vitamins and minerals for which Nutrient Reference Values (NRVs) have been laid down in the Guidelines for nutrition labelling (ii) Nutrition claims shall conform to the requirements in EAS 804 and shall not supersede any prohibitions contained therein Nutrition claims shall not be made for foods for infants and young children except where specifically provided for in relevant East African or National Standards or national legislation.
4. Nutrition content claims	(i) When a nutrient content claim that is listed in Table 1 in the Standards, or a synonymous claim is made, the conditions specified in that table for that claim shall apply (ii) A claim to the effect that a food is free of salt can be made, provided the food meets the conditions for free of sodium listed in the table Where a food is by its nature low in or free of the nutrient that is the subject of the claim, the term describing the level of the nutrient shall not immediately precede the name of the food but shall be in the form "a low (naming the nutrient) food" or "a (naming the nutrient)-free food".

Box 5.5 cont'd

APPLICABLE UNBS CODES

Uganda Standard US EAS 805 Use of nutrition and health claims – Requirements cont'd	
Section/title	**Key provisions/text**
5. Non-addition claims	Claims regarding non-addition of sugars to a food may be made provided the following conditions are met: • no sugars of any type have been added to the food (examples: sucrose, glucose, honey, molasses, corn syrup, etc.); • the food contains no ingredients that contain sugars as an ingredient (examples: jams, jellies, sweetened chocolate, sweetened fruit pieces, etc.); • the food contains no ingredients containing sugars that substitute for added sugars (examples: non-reconstituted concentrated fruit juice, dried fruit paste, etc.); and • the sugar content of the food itself has not been increased above the amount contributed by the ingredients by some other means (example: the use of enzymes to hydrolyse starches to release sugars).
6. Non-addition of sodium salts	Claims regarding the non-addition of sodium salts to a food, including "no added salt", may be made provided the following conditions are met: • the food contains no added sodium salts, including but not limited to sodium chloride, sodium tripolyphosphate; • the food contains no ingredients that contain added sodium salts, including but not limited to Worcestershire sauce, pickles, pepperoni, soya sauce, salted fish, fish sauce; • the food contains no ingredients that contain sodium salts that are used to substitute for added salt, including but not limited to seaweed; and • sodium salts other than sodium chloride may be added for technological purposes as long as the final food would still comply with the conditions for "low in sodium" claims as described in Table 1 in the standard.

Box 5.5 cont'd

APPLICABLE UNBS CODES

Uganda Standard US EAS 805 Use of nutrition and health claims – Requirements cont'd	
Section/title	**Key provisions/text**
7. Health claims	(i) Health claims are permitted provided they are based on relevant scientific substantiation and the level of proof must be sufficient to substantiate the type of claimed effect and the relationship to health as recognized by generally accepted scientific review of the data and the scientific substantiation should be reviewed as new knowledge becomes available. (ii) The claim shall consist of two parts: • information on the physiological role of the nutrient or on an accepted diet-health relationship; followed by • information on the composition of the product relevant to the physiological role of the nutrient or the accepted diet-health relationship unless the relationship is based on a whole food or foods whereby the research does not link to specific constituents of the food (iii) The claimed benefit shall arise from the consumption of a stated quantity of the food or food constituent in the context of a healthy diet. (iv) If the claimed benefit is attributed to a constituent in the food, for which a Nutrient Reference Value is established, the food in question shall be: • a source of or high in the constituent in the case where increased consumption is recommended; or, • low in, reduced in, or free of the constituent in the case where reduced consumption is recommended. Where applicable, the conditions for nutrient content claims and comparative claims will be used to determine the levels for "high", "low", "reduced", and "free". (v) Labelling of a health claim shall bear the following information: • a statement of the quantity of any nutrient or other constituent of the food that is the subject of the claim; • the target group, if appropriate; • how to use the food to obtain the claimed benefit and other lifestyle factors or other dietary sources, where appropriate; • if appropriate, advice to vulnerable groups on how to use the food and to groups, if any, who need to avoid the food; • maximum safe intake of the food or constituent where necessary; • how the food or food constituent fits within the context of the total diet; and a statement on the importance of maintaining a healthy diet.

Box 5.5 cont'd

APPLICABLE UNBS CODES

Uganda Standard US EAS 805 Use of nutrition and health claims – Requirements cont'd	
Section/title	**Key provisions/text**
8. Claims related to dietary guidelines or healthy diets	Claims that relate to dietary guidelines or "healthy diets" shall be subject to the following conditions: • only claims related to the pattern of eating contained in dietary guidelines officially recognized by the appropriate national authority; • flexibility in the wording of claims is acceptable, provided the claims remain faithful to the pattern of eating outlined in the dietary guidelines; • claims related to a "healthy diet" or any synonymous term are considered to be claims about the pattern of eating contained in dietary guidelines and shall be consistent with the guidelines; • foods which are described as part of a healthy diet, healthy balance, etc., shall not be based on selective consideration of one or more aspects of the food. They shall satisfy certain minimum criteria for other major nutrients related to dietary guidelines; • foods shall not be described as "healthy" or be represented in a manner that implies that a food in and of itself will impart health; and • foods may be described as part of a "healthy diet" provided that the label carries a statement relating the food to the pattern of eating described in the dietary guidelines.
Uganda Standard US EAS 35 Fortified food grade salt – Specification	
Purpose	• The Standards have been adopted from the EAC standards on fortified food grade salt the use of which is envisaged will facilitate adoption of food fortification as a strategy to prevent, alleviate or eliminate micronutrient deficiency in the region. Standards will not only promote the health of the population but will also ensure safety of food products and enhance fair trade.
Labelling	(i) The name of the product shall be "Fortified food grade salt", "Iodated food grade salt" or "Iodated edible salt". The name shall have in its close proximity a declaration of either coarse salt or, crushed salt or table salt. Where salt is also used as a carrier for other nutrients, the name of the product shall be indicated on the label for example "Salt fortified with vitamins" or "Salt fortified with Iron" The level of iodine in mg/100g must be shown on the label along with a complete list of ingredients including food additives in descending order of proportions.
Health claim	Fortified food grade salt may have claims on the importance of the vitamins and minerals in nutrition and health.

NRV: nutrient reference value; UNBS: Uganda National Bureau of Standards.

A5.2 Physical activity

A5.2.1 Ministry of Education and Sports

Uganda's Department of Physical Education and Sports (PES) has the mandate to develop and coordinate all physical education and sports activities in the country, as stipulated in the National Physical Education and Sports Policy (NPESP) (5). It is the mission of the Government of Uganda to guide, coordinate and promote quality physical education, training and sports to all persons in Uganda for national integration, development and individual advancement. Key functions of this department are to:

- initiate legislation and policy formulation, and provide guidelines for PES;
- build the capacity of teachers, coaches and other stakeholders, and conduct support supervision for quality assurance;
- coordinate the organization of sports competitions and provide sports equipment, instructional materials and facilities for talent identification and development at educational institutional levels;
- guide, coordinate and monitor strategic planning and budgeting for PES;
- liaise with the National Council of Sports on issues regarding National Sports Federations and Associations;
- oversee advocacy for PES in the areas of resource mobilization, favourable legal framework and tax provision on sports goods, equipment and prizes;
- liaise with sports stakeholders including NGOs to develop and promote public private partnerships in the planning, financing and provision of PES; and
- coordinate and monitor the day-to-day management of PES activities in the country.

A5.2.2 Physical Planning Act 2010

Under Section 19 of the Physical Planning Act 2010, the national and regional development plan shall be prepared for improvement of an area and for providing for proper physical development (6). This plan shall adequately provide for agriculture development, infrastructure, industrial development, environmental protection, natural resource management, urbanization and human settlements conservation. There is no stipulation for provision of open spaces or parks.

A5.2.3 Town and Country Planning Act 1951

An outline scheme under the Town and Country Planning Act 1951 should provide for the reservation of lands as open spaces (7) (Section 10 as read with the Second Schedule).

A5.2.4 Traffic and Road Safety Act 1998

Part VI of the Traffic and Road Safety Act 1998 contains provisions on the use of motor vehicles (8). Section 131 stipulates that, under this part, regulations can be formulated for:

(a) regulating the control of pedestrians on roads; and
(b) making provision for ensuring adequate safety for cyclists and pedestrians and persons with inability and disability on the road and, in particular, the provision of rack or rump for storage of support equipment used by persons with a disability.

References for Annex 5

1 Food and Drugs Act, Uganda. 1959 (https://www.parliament.go.ug/cmis/browser?id=72f6c535-6e82-4838-a3a5-aaba9a151dc1%3B1.0).

2 Communications Act, Uganda. 2013 (https://www.ucc.co.ug/files/downloads/UCC%20Act%202013.pdf).

3 The Advertising Standards, Uganda Communications Commission. 2018 (https://www.ucc.co.ug/wp-content/uploads/2018/05/Advertising-standards.pdf).

4 National Bureau of Standards Act, Uganda. 1983 (https://www.unbs.go.ug/attachments/menus/47/Uganda-National-Bureau-of-Standard-act.pdf).

5 About us, Ministry of Education and Sports, Uganda. 2019 (http://www.education.go.ug/#eluidd49b9abd).

6 The Physical Planning Act, Uganda. 2010 (https://www.ecolex.org/details/legislation/physical-planning-act-no-8-of-2010-lex-faoc140395/).

7 Town and Country Planning Act, Uganda. 1951 (https://old.ulii.org/ug/legislation/consolidated-act/246).

8 Traffic and Road Safety Act, Uganda. 1998 (https://ulii.org/akn/ug/act/1998/15/eng%402020-05-22).

9 The Occupational Safety and Health Act, Uganda Legal Information Institute. 2006 (https://old.ulii.org/ug/legislation/act/2015/2006-10).