2nd African colloquium on public health, law, and human rights in Africa
'Noncommunicable diseases, healthy diets and (human rights) law'
Hybrid event with the Groningen Centre for Health Law Summer School 2022

Co-hosted by the University of Groningen, Netherlands, and
Moi University and the University of Nairobi, Kenya
Friday, 15 July 2022

Colloquium Report

Background to the colloquium

Conversations on the use of law and human rights to promote health are still relatively infrequent in Africa. This colloquium focused on NCDs, health diets and (human rights) law. It was the second colloquium of 2022, co-hosted by Moi University, University of Nairobi, and the University of Groningen, to address the role of the law and human rights in protecting and promoting the right to health.[1] This report presents some of the perspectives shared by the panellists, the discussants, and the participants. It does not aim to be a comprehensive summary and does not reflect the views of any one person or institution.

NCDs are currently responsible for about 74% of total deaths globally. This figure varies greatly by region and is increasing in all regions over time. In Sub Saharan Africa, NCDs caused 37% of the total deaths in 2019, which was an increase from the 24% of total deaths recorded in 2000. In Tanzania, for example, total deaths from NCDs increased from 21% in 2000 to 34% in 2019.[2]

Success in reducing deaths from communicable (infectious) diseases means that the percentage of all deaths attributable to noncommunicable diseases (NCDs) has increased. This is the so-called global 'epidemiological transition' from communicable diseases to NCDs. If this relative increase in NCD-related mortality (when compared with infectious diseases and injuries) was only in populations aged over 70, this transition might indicate a general improvement in population health.

However, it is of great concern that NCD-related morbidity and mortality *is increasingly affecting populations aged under 70.* These are people still in their productive years, often with families to support. Further, this increase is more rapid in low- and middle-income countries (LMICs). Globally, more than 15 million people between the ages of 30 and 69 years die from an NCD annually - 85% of these "premature" deaths occur in LMICs.[3] For example, the probability of premature death from NCDs in Kenya is 21; in Ghana it is 22%; in South Africa it is 24%. In the Netherlands it is 10%.[4]

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[1] For the report of the first colloquium, refer to the Events webpage of the Groningen Centre for Health Law.
[2] Cause of death, by NCDs (% of total) – Tanzania. www.data.worldbank.org
[3] NCDs – Key Facts (WHO)
[4] Noncommunicable Diseases Progress Monitor 2022 (WHO)

Major risk factors that exacerbate NCDs are tobacco use, unhealthy diets, lack of physical activity and the harmful use of alcohol. Mental disorders are the leading cause of years lived with disability (YLDs).[5]

Law and policy issues regarding noncommunicable diseases in Africa

The population of Africa reached 1.4 billion in 2022. Globally, 1 in 5 people is from Africa and 60% of this population is below 25 years of age. This young population expects to celebrate its 60th birthday in good health. Laws and policies should therefore include a focus on the prevention of disease. However, the health sector in Africa still largely focuses on curative rather than preventative approaches. Laws and policies are not sufficiently utilized to address NCD risk factors. Yet, prevention is essential to curbing NCDs in Africa. Implementation and accountability can also be challenges that must be addressed.

Human rights, including the principle of participation, can play an important role in influencing the design of interventions. When public health laws are formulated, interventions should be co-designed. This means we need to understand how laws influence public health interventions. We need to fit the recommendations of public health professionals into the existing legal systems.

For example, in Tanzania, most of the relevant laws do not take a precautionary approach towards health promotion, even though waiting until disease occurs and then acting to cure it is more costly. More evidence of cost-effectiveness is required: there have been insufficient efforts to cost the promotion of health through the prevention of disease.

Noncommunicable diseases and public health law and policy in South Africa

South Africa provides an example of the implementation of preventive policies and laws. The South African Constitution not only recognizes the right to health care, it also recognises other determinants of health. This allows a holistic approach to the right to health, by drawing the links between the right to food, the right to water etc., and the right to health.

South Africa has adopted some of the most pioneering NCD prevention laws in the world. It was one of the first countries to adopt comprehensive tobacco control measures; one of the first countries to adopt mandatory limits on sodium in certain types of food; to ban trans fats; and to introduce comprehensive infant formula regulation. It was also the first country in Africa to adopt a tax on sugar-sweetened beverages that was linked to the sugar content of the beverages, thus aiming to disincentivize their consumption.

The most important lesson from the approach of South Africa is that health policy research should be responsive to the context of each country. Many African countries are facing a double burden of both infectious and noncommunicable diseases. Further, many African countries including South Africa have a double burden of malnutrition – both under and over-nutrition (leading to obesity). Policies and legal responses to address these double burdens should be identified by paying attention to the context in which these policies and laws are operating.

Noncommunicable diseases and public health law and policy in Kenya

Tobacco use and alcoholic drinks are subject to specific legislation in Kenya. Unhealthy diets and the lack of physical activity remain possible areas of legal intervention. This is despite the Kenyan Health Act of 2017, which defines health broadly as “the complete state of physical, mental, social wellbeing and not

[5] See generally World Mental Health Report: Transforming mental health for all 2022 (WHO)

merely an absence of diseases". However, the Health Act of 2017 tends to focus on pharmaceutical issues and not on preventive measures. The conceptual framework of the Act overlooks the management and control of unhealthy diets and physical inactivity as risk factors for NCDs. These are left to separate public health laws, which are implemented by local authorities.

The challenge is to reconfigure the conversation around the risk factors for NCDs in Kenya so they are recognised as a health issue. This can be done, for example, by addressing the risk factors for NCDs in the employment and labour settings. For instance, health insurance is a discretionary employment benefit. However, it can only be accessed after the employee has an injury or has contracted a disease. That overlooks what should be done with the employee while he/she is still healthy to prevent him/her from being at risk of NCDs. Therefore, one of the areas that can be analysed is how physical activity, nutrition, and dietary information for employees can be part of a national conversation.

To be effective, public health laws should be both well-designed and well-enforced. Unfortunately, Kenya is an example where tobacco laws are not well enforced. Smoking in public is banned in Kenya, yet it is up to local authorities to interpret and enforce the law. For example, in Nairobi five zones were established where smoking was legally permitted. However, they were closed because they proved to be a nuisance to people who worked in the neighbourhood. Now people continue to smoke openly in public places.

Health policies, the economy, and consumer protection: While regulating for health, the economy also has to be protected. How this should be handled is a matter of concern. For instance, sugar sweetened beverages may be taxed to promote healthier diets. In addition, consumer consultation and education is essential regarding the benefits of proposed legislation when public health laws are formulated.

Risk factors for NCDs outside the health sector: NCDs are affected by factors such as the availability of healthy food, and road construction to permit active transport (including walking and cycling). The availability of healthy food, road design and the like are governed by sectors outside of the public health sector. For example, engineers often do not consider pedestrians and cyclists when they design roads. Similarly, land laws and land use should be revisited: land laws could require that certain portions of land should be set aside for physical activity during the development of housing and infrastructure. Research is needed, yet governments in the global South usually do not allocate funds for research in these areas. Further, how do we monitor the implementation of policies affecting NCD risk factors which lie outside the health sector?

Consultation and participation in the co-designing of public health interventions: When there is a high-level consultation on a proposed intervention, participation should be balanced. Industries use industry associations and lobby groups to make and coordinate their responses to such interventions. They also use exclusive channels of access. When government bodies only consult industry lobby groups, these groups are often able to influence and dilute interventions. In more public processes, industry lobby groups tend to have less influence. Governments should adopt consultation mechanisms that include civil society, academia, and the health sector. Similarly, when research organizations have close relationships with civil societies and government actors, the research will likely have more impact. However, research organizations also need to preserve their independence.

Improving diets and preventing NCDs: There is a double burden of nutrition, malnutrition, and over nutrition in Africa. The consumer is generally not protected from unhealthy diets. For example, there are a lot of billboards across urban centres that advertise cheap foods high in salt, sugar and fat. There is no

law that imposes the inclusion of a plant-based dietary option in most of the fast-food sector. Yet people have a right to nutritious foods at affordable prices.

While much of the debate is in its infancy not just in Africa but globally, there are a lot of existing measures and mechanisms that can be used to improve diets and prevent NCDs. The most obvious is to take the lessons that have been learned from tobacco. Where laws are already in place, monitoring and enforcement of existing policies should be considered before new legislation.

Quality of food: Food quality in Africa is not yet assured from the harvest until it is put on the plate. Although biological fertilizers are safer, fertilizers with carcinogenic risks are also used. In addition, there are traders who reduce the quality of food products and increase their health risks by introducing unwanted substances. For instance, there are traders who ripen fruits such as bananas using bicarbonate of soda. Vegetables are sometimes washed with sewage water. Public health laws need to be strengthened in these areas.

Climate factors: In Africa, the climate is becoming wetter and more humid in some areas. There is an increased risk of aflatoxins in agricultural crops in the field, at harvest and during storage. This brings an increased risk of liver cancer and related morbidity and mortality. Health laws should be formulated to minimize this risk, considering the effect of the changing climate.

Tobacco control in Africa: Tanzania

Tobacco consumption is a major risk factor for NCDs. What can be the human rights case against the tobacco industry, considering the industry as an entity that has an independent human rights responsibility alongside governments? Should the industry should go out of business as a result? This would have serious economic consequences in countries such as Tanzania, where tobacco is the second largest export product.

Tobacco use is increasing: adult smoking prevalence in Tanzania reached 6% in 2019. In 2020, 4.5 million cigarettes were sold. More than 50% of Tanzania's population is aged between 15 and 24 years of age: the effect of 4.5 million cigarettes can clearly be understood. Tanzania ratified the WHO Framework Convention on Tobacco Control in 2007 and has two regulations on tobacco: The Tobacco Product Regulation Act of 2003 and the Tanzania Tobacco Regulation Act of 2017. The latter Act bans:

- Smoking in public places (although this needs much enforcement);
- Advertising of tobacco products; and
- 'Corporate social responsibility' initiatives by tobacco companies.

The regulations also require tobacco packages to display messages on the negative health effects of tobacco in local languages. (The packages used to display the health messages in English.) One of the many challenges in tobacco regulation is that tobacco companies have close relationships with the police and other government actors. For example, the Tanzanian State has a share in one of the largest tobacco companies in Tanzania.

Trends in litigation to address NCDs: Uganda

Many African Constitutions not only recognize the vertical relationship that exists between the State and the citizen as rights-holder, they also recognise the horizontal application of human rights which, especially regarding interventions on NCDs, affects the financial capability and legal rights of businesses and multinational corporations.

Many African governments are now working with the private sector in so-called 'public-private partnerships.' Large corporations such as the tobacco and food & beverage industries also contribute significantly to government revenue through taxes, and have tremendous power. However, this should not deter legal cases against these industries to protect public health. Litigation is one avenue in sub-Saharan Africa to address the problems of adequate food and nutrition.

In Uganda, 33% of deaths are caused NCDs, largely as a result of unhealthy diets, which cause obesity, diabetes, cancer, cardiovascular disease and other diseases. Malnutrition is also a problem because a substantial proportion of the population is food insecure.

Neither the right to adequate food and nor the right to health are specifically mentioned in the Ugandan constitution. However, these rights are protected under international and regional treaties to which Uganda is a party, and the general objectives of government. Ugandan civil society organisations (CSOs) have therefore taken legal action to assert the right to adequate food and to health. In a recent victory, the Uganda courts declared that everyone has the right to adequate food. CSOs are now filing cases to expand the jurisprudence on the issue.

The right to information should also be respected. The right to information is recognized in international treaties, the Ugandan Constitution, and other laws in Uganda. Some food corporations engage in unethical advertising. CSOs are working with universities, research hubs, and academia to encourage research to help policy makers, government actors, and the courts provide clear legal guidance on issues such as ethics in food processing, advertisement, and packaging, including nutrition labelling.

Many officials and judicial actors in Uganda do not understand or recognise the right to adequate food. A lot of work needs to be done to help the power brokers, justice actors, and university academics understand the sources of the right to health and adequate food. For example, a colloquium could be held on the how right-to-health litigation can be based on civil and political rights, including the right to life. Clarity is needed on the normative content of the right to food.

Decolonizing global health: The attention given to NCDs is waning. Funding for NCDs is drying up globally. This is because NCDs do not cross borders and they are not being taken seriously by those who have the power to set the global health agenda.

Decolonization in the context of global health refers to the power imbalance that is seen in the practice of global health. It is manifested in many ways. Funders are particularly perpetrating colonialism in global health. Even though they are not a homogenous group, some of them share common characteristics and behaviours. Broadly speaking, funders, international development agencies, and private philanthropies, are domiciled in high income countries. They hold tremendous power over the practice of global health. For example, they set the research agenda and decide how and to whom resources are allocated. They have argued that there is a lack of capacity in the global South in terms of technical research and administrative capacity. However, even when local capacity exists, we continue to see this bias towards institutions and practitioners outside the global South. As a result, funders need to re-examine their grant making practices and prioritization mechanisms. Who sits at the table within these organizations matters. If you have a peer review panel that is sufficiently diverse, some of the biases could be addressed.

Key takeaways from the colloquium

I. **Decolonise global health research:** Interventions to address NCDs in Africa are often based on research in the global North and lack a foundation in local research. Research funders from the global North need to ensure global South representation in funding bodies.

II. **Engage and educate the public in NCD policy design and implementation:** Communities need to be consulted in the design and implementation of NCD policies. After sound public health laws are put in place, there is also a need to educate consumers to understand and follow them. In general, adequate awareness of and implementation of laws is important for the benefits of a policy to be reaped.

III. **Engage non-health sectors in policies affecting NCD risk factors:** Other sectors affecting diets including agriculture – farm to fork policies – and physical infrastructure must be engaged to facilitate physical activity and broaden the concept of health interventions beyond a curative focus.

IV. **Capacity development:** capacity should be improved in public health research and advocacy. Public health advocacy in Africa should be supported and led by African researchers.

V. **Address economic interests:** Economic actors wield immense power. In the African context, how should we manage the conflict between the interest of economic actors and public health? Or rather, are there novel ways to harmonize economic and social developments with public health objectives, including regulation of companies in the public interest?

VI. **Utilise the UN and regional human rights system, and engaging world trade-related procedures:** In Africa, there are powerful companies including in manufacturing, agricultural pesticides, and the food industry. These corporations, and the national governments which regulate them, need to be accountable for their impact on NCDs, and public health generally. The UN and regional human rights system and world trade-related procedures are important mechanisms to assist achieve this objective.

Suggested next steps after the colloquium

1. Organize colloquia at national level to help legal actors and other stakeholders understand the right to health, the right to food and other socio-economic rights.

2. Prepare a clear text and legal digest on the normative content of the right to food in Africa.

Research priorities for legal action to address NCDs in Africa

1. The intersection of environmental issues in the production and distribution of healthy foods and how environmental issues exacerbate NCDs in the context of food production and distribution.

2. Cost-effectiveness of health promotion interventions.
3. Ways to reduce prices of healthy foods and increase tobacco prices.
4. Addressing the human rights responsibilities of food and beverage industries.
5. Marketing of unhealthy foods.
6. Establishing and enforcing regulations.
7. Legal input to co-designing interventions to address NCDs.
8. Risk factor mapping for NCDs at national level to provide preliminary data for grant applications.
9. Identification of knowledge and practice gaps in individual risk-taking behaviour for NCD prevention.
10. Food contamination practices by vendors.
11. Access to healthy foods.
12. Regulation of big sugar companies.
13. Long term effects and impacts of environmental toxins.

Closing remarks

This conversation is multi-disciplinary and requires diverse expertise, including of economists, human rights scholars and activists, health practitioners, policy makers, politicians, environmentalists, agriculturalists, and legal practitioners. Researchers in the global South need to move the conversation forward by actively involving and engaging in research from each of these perspectives.

Suggested reading

- Safura Abdool Karim et al, The legal feasibility of adopting a sugar-sweetened beverage tax in seven Sub-Saharan African countries (2021) 14 Global Health Action
- Maurice Oduor, Toolkit on regulatory approaches to noncommunicable diseases: healthy diets and physical activity (2022) IDLO

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