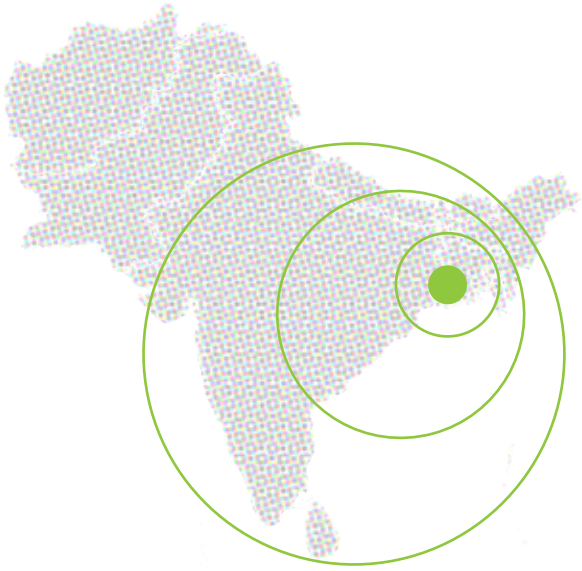

Toolkit on regulatory approaches to noncommunicable diseases: healthy diets and physical activity

(South Asia edition)

IDLO
Creating a Culture of Justice
International Development Law Organization

Contents

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The publication draws on background reviews undertaken by WHO, involving desk research into the legal and policy frameworks for Bangladesh and Sri Lanka that are relevant to the governance of healthy diets and physical activity. The lead author was Dr Himani Bhakuni, Assistant Professor of Justice in Global Health Research at University Medical Center, Utrecht University, and Lecturer in Law at Maastricht University. We acknowledge the contribution of Dr Dayanath Jayasuriya, President's Counsel and Executive Director of the Institute of Comparative Health Policy and Law, to the conception and early draft of the publication. Valuable comments were also provided by Malay Kanti Mridha, Mostafa Hosain, Rizwanul Islam and Shamsuddin Mahmood. We would also like to thank Syed Mahbubul Alam Tahin, Secretary at the Center for Law and Policy Affairs, for reviewing and integrating the legal analysis for Bangladesh. IDLO also acknowledges the members of the Global RECAP academic working group (Bangladesh), listed below, and experts from Sri Lanka who reviewed the draft.

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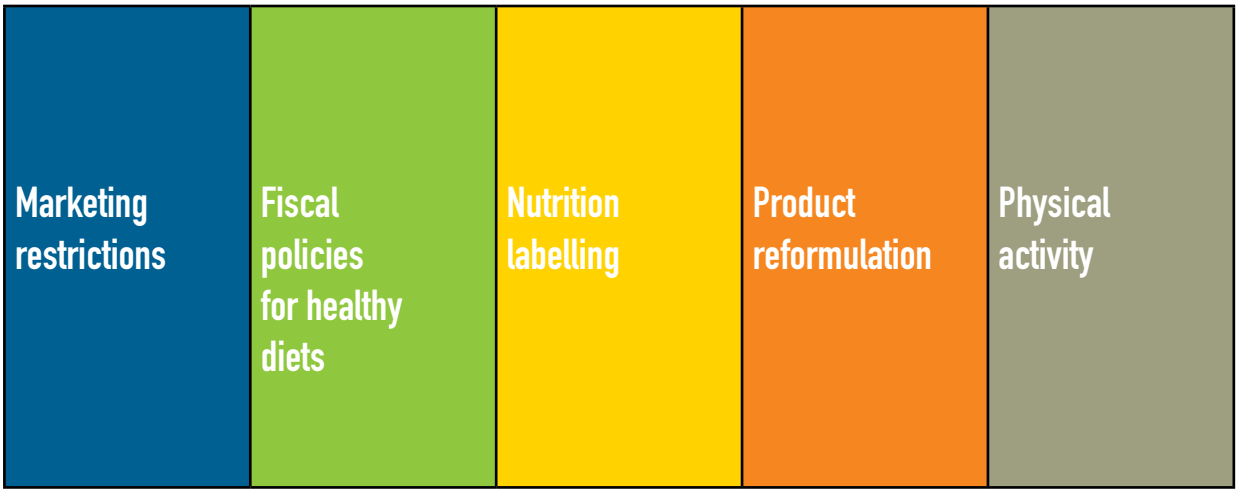
Preface

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. Such frameworks can promote healthier diets and more exercise.

The World Health Assembly and the World Health Organization (WHO) have recognized the role of policy, laws and regulations (e.g., regulatory and fiscal reforms) to address NCDs, including through international policy instruments, such as 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 for reaching that goal. Further, target 3.4 of Agenda 2030 states, "By 2030, reduce by one third premature mortality from noncommunicable diseases through prevention and treatment and promote mental health and wellbeing".

The Global Regulatory and Fiscal Capacity Building Programme (Global RECAP) is a collaborative project between the International Development Law Organization (IDLO) and WHO, in coordination with the International Development Research Centre. In its first phase (2019-2022), Global RECAP was supported by the **Swiss Agency for Development and Cooperation** (SDC) and the **OPEC Fund for International Development**. 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 East Africa and South Asia. The Programme policy focus areas are shown in the figure below. Each country has prioritized the areas relevant to their national context.

Regulatory and fiscal policy focus



This toolkit is focused on policy responses to NCDs in South Asia; however, 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 the region.

The 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 two countries in South Asia: Bangladesh and Sri Lanka.

Foreword

Throughout the world, people are being 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 disease (COVID-19). In South Asia, 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 their students' capacity 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 two countries – Bangladesh and Sri Lanka – situating their 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 those countries, convened to reflect on the role of the law in the response to NCDs in South Asia. 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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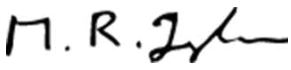

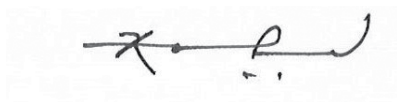

Abbreviations and Acronyms

AIDS	acquired immunodeficiency syndrome
BMI	Body Mass Index
CEDAW	Convention on the Elimination of all Forms of Discrimination against Women
CRC	Convention on the Rights of the Child
CRD	Chronic Respiratory Disease
Ct	Carat
CVD	Cardiovascular Disease
FAO	Food and Agriculture Organization of the United Nations
GHO	Global Health Observatory
GLOBAL RECAP	Global Regulatory and Fiscal Capacity Building Programme
HIV	Human Immunodeficiency Virus
HPNSDP	Health Population and Nutrition Sector Development Program
ICCPR	International Covenant on Civil and Political Rights
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
MoU	Memorandum of Understanding
NAB	Non-Alcoholic Beverage
NCD	Noncommunicable Disease; Non-communicable Disease
NGO	Nongovernmental Organization
NRV	Nutrient Reference Value
NUGAG	WHO Nutrition Guidance Expert Advisory Group
ppm	parts per million
PUCL	People's Union for Civil Liberties
SAARC	South Asian Association for Regional Cooperation
SD	Standard Deviation
SDG	Sustainable Development Goal
SLSI	Sri Lanka Standards Institution
SSB	Sugar-Sweetened Beverage
UN	United Nations
UNCESCR	United Nations Committee on Economic, Social and Cultural Rights
VAT	Value Added Tax
VGFSyN	Voluntary Guidelines on Food Systems and Nutrition
WAPDA	The Pakistan Water Resources and Power Development Authority
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 2013–2020 (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 the implementation of these interventions 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 two key risk factors – unhealthy diets and physical inactivity – in two countries of South Asia: Bangladesh and Sri Lanka. 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]

The two risk factors that are the focus of this toolkit (i.e. unhealthy diets and lack of physical activity) appear to have attracted scant legal attention. The aim of the toolkit 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 Bangladesh and Sri Lanka. 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

[1] For example, in the case of Sri Lanka, domestic alcohol regulation can be seen through instruments such as the National Policy on Alcohol Control (2016) and regional alcohol control efforts can be seen through the adoption of the regional policy (Colombo Declaration, 2016) on Strengthening Health Systems to Accelerate Delivery of Noncommunicable Diseases Services at the Primary Health Care Level (7).

measures that will reduce premature 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 nonalcoholic 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.[1] As mentioned above, this publication focuses on two countries in South Asia: Bangladesh and Sri Lanka. With few exceptions, undergraduate training of legal and public health professionals in these countries does not include the role of law 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 an academic resource common to different disciplines, the toolkit may stimulate and strengthen dialogue among 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 Bangladesh and Sri Lanka relevant to the governance of healthy diets and physical activity. The findings of that research were supplemented through additional research on law and policy relevant to NCD prevention and control conducted by the Global Regulatory and Fiscal Capacity Building Programme (Global RECAP) academic working group members and partners. Data and information on international, regional and national policies and legislation are updated to 2022.

The publication also involved a participatory and consultative process with academics from schools of law and schools of public health from the two 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 reviewed by 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.

[1] 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 South Asian regional context, by highlighting regional cooperation on NCDs. It also provides examples of strategies from the South Asian region for addressing NCDs by using legal and human rights approaches.

- Part D provides the South Asian subregional context, by:

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

Annexes provide additional exercises (Annex 1), data on NCDs for Bangladesh and Sri Lanka (Annex 2), and further details of relevant legislation in the two countries (Annexes 3 and 4).

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 human immunodeficiency virus (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-related 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).

NCDs – chiefly cardiovascular diseases, cancers, chronic respiratory diseases and diabetes – claim an estimated 8.9 million lives each year in the WHO South-East Asia Region, which comprises Bangladesh, Bhutan, the Democratic People's Republic of Korea, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Thailand and Timor-Leste (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 behaviour 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, which can also be prevented and controlled.

NCD-related deaths increased globally in the period 1990–2019 (24). In the WHO South-East Asia Region, as of 2015, 25.1% and 8.6% of the adult (aged >18 years) regional population had raised blood pressure and elevated blood glucose, respectively (25). According to Global Health Estimates 2015, hypertensive heart diseases were directly estimated to cause 5.7% of all cardiovascular deaths in this region (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. In 2022, the World Health Assembly (WHA) plans to adopt a roadmap for achieving the targets of the Global Action Plan on NCDs by 2030.

2.2 NCDs and gender

NCDs and their risk factors affect men and boys differently from women and girls. Throughout the WHO South-East Asia Region, data show higher rates of raised cholesterol levels and overweight and obesity among women than men (24).[1] Also, levels of physical activity are often higher among men than women. 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 exertion unfavourably with norms of femininity may lead to criticism of girls when they engage in sporting activities that defy cultural stereotypes about the roles of men and women (27). Parents become part of the social reinforcement continuum for gender stereotypes when they disapprove of norm-defying tendencies among their children (28).

NCDs during pregnancy can lead to increased maternal morbidity (hypertensive pregnancy disorders such as pre-eclampsia and eclampsia, overweight and obesity, and depression) and mortality (29). Also, 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 (30).

[1] 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 (26). 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.

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 Food and Agriculture Organization of the UN (FAO) (31). In 2019, guidance from WHO and FAO noted that there are divergent views on the concepts of sustainable and healthy diets and suggested that "countries should decide on the trade-offs according to health situations and goals" (31). 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 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 and nuts, and in 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 prepackaged 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.

NCD: noncommunicable disease; WHO: World Health Organization.

2.3.2 Physical activity

Physical activity refers to any bodily movement produced by skeletal muscles that requires expenditure of energy (36). 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 policies 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), and 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, 37).

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.

WHO: World Health Organization.

2.4 Exercises

1. Explain the relationship between gender and NCDs.
2. Describe local practices and beliefs 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 diseases.
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 (38, 39). They accrue to every human being, regardless of nationality, sex, national or ethnic origin, colour, religion, language or other status (40). Further, all human rights are "universal, indivisible and interdependent and interrelated" (41).

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 three key human rights documents: the *Universal Declaration of Human Rights* (42), the *International Covenant on Economic, Social and Cultural Rights* (ICESCR) (43) and the *International Covenant on Civil and Political Rights* (ICCPR) (44). 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 – for example, women, children, people with disability, 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 and 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, working together 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 (45). In addition, some States have proposed a binding treaty on business and human rights (46).

Conflicts of rights may arise in the implementation of public health measures to address NCDs (e.g. on 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 they may be subject to strict legal tests (47). 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 those communities. In the Asian context, cultural and religious concepts also contribute to the understanding of individual and collective rights and responsibilities (48).

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 (42), the right to health is 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 (43) 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 (49).
	(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." (50) States are obligated to take steps that will reduce or eliminate environmental and industrial hazards to health.
	(c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;	States parties must take measures to prevent, treat and control NCDs.
	(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 UN Committee on Economic, Social and Cultural Rights (UNCESCR). 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 (51), 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. However, they will include 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 marginalized groups such as women, children, older persons, ethnic minorities, people with disability, 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, and sensitive to gender and life-cycle requirements). Also, they should be 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 (51, 52).

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 …" (51). UNCESCR also noted that (51):

> 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 (53)). 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" (54). 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 (55).

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) (56). 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" (56) – 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 (57). In addition, many NCD-precipitating behaviours are adopted early in the life of a person (58). 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 child's quality of life and development. 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 (59). The comment envisages children's right to health as an inclusive right that extends not only to prevention, health promotion, and 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 achieve 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 (60). 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 (59)
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 (61).
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) (62) 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 (63). 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 (64); 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 (65).

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 Bangladesh; having passed the Smoking and Tobacco Products Usage (Control) Act, 2005, Bangladesh subsequently benefited from civil society involvement in a review of that legislation in 2013, which culminated in an amendment (66).

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 WHA. 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 (67). For instance, through policy intervention it is possible to require that the food industry produces foods that have a limited content of fat, sugar and salt, 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 healthy choices (e.g. in preventing diabetes and other NCDs) (68). 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 population-wide approaches (69)

In the 1960s, Finland had the world's highest number of 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 (69). However, there are concerns about 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 (70). 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 (71).

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 (72, 73). However, bilateral and regional investment treaties do not necessarily include such a public health exception, and they 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 (74). In addition, bilateral investment treaties can be used to limit the manner in which a State regulates NCDs, especially during negotiations (75). 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 (76)
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 (77)
2012	WHO	A framework for implementing the set of recommendations on the marketing of foods and NABs to children (78)
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 (79)
2015	UN	Transforming our world: the 2030 Agenda for Sustainable Development (80)
2017	WHA	Tackling NCDs: 'best buys' and other recommended interventions for the prevention and control of noncommunicable diseases (81)
2018	UN	Political Declaration of the Third High-Level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases (82)
2018	WHA	Global Action Plan on Physical Activity 2018–2030: more active people for a healthier world (83)
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 (84)[a]
2022	WHA	Updated list of NCDs 'best buys' (81)
2022	WHO	WHO Acceleration Action Plan to Stop Obesity

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 (80), 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 (80). 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 means that they all have implications for health and hence provide overarching principles that frame responses to NCDs (see Fig. 4.1) (85). 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, nutritious and sufficient 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 (86, 87).

Figure 4.1

SDGs AND HEALTH

SDG: Sustainable Development Goal.
Source: WHO (2021) (85).

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 (77) 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 (88, 89).

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 (76); 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 (79) 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 (82), Member States reaffirmed their commitment to accelerate the implementation of the measures they had committed to in the 2011 political declaration (77) and the 2014 outcome document (79). 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" (82). 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" (82). 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 (90), the Global Action Plan on Physical Activity 2018–2030 (83) and the Global Strategy on Diet, Physical Activity and Health (76).

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 (76) is a general strategy document adopted by the WHA. 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 (91).

Key recommendations of this global strategy are reflected in the 2011 political declaration (77). 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) (92).

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, 93). In 2010, the WHA adopted recommendations for Member States on the marketing of foods and NABs to children (94). 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 (76) that Member States develop appropriate multisectoral approaches to deal with the marketing of foods 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 foods 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 (78). 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 WHA in 2013; it includes six objectives and nine voluntary NCD targets (2). The original plan covered the period to 2020; however, in 2019, the WHA extended it to 2030, to align with the 2030 Agenda for Sustainable Development (84). 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 are contained in Appendix 3 of the action plan. In 2017, these options were updated (81) 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 (80). 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 are encouraged to select their own best buys based on their national context and priorities. The selection process will take 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.[1] 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 (81). Taxation of sugar-sweetened beverages (SSBs) 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.[2] Another 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 (81). An updated list of 'best buys' was approved at the 76th WHA in 2022.

Physical activity best buys

In the context of physical activity, one best buy is to implement a "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" (81). Providing physical activity counselling and referral as part of routine primary health care services is included as an effective intervention with a lower cost–effectiveness ratio. Recommended interventions also 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 WHA in 2018 and provides guidance and a framework of policy actions to increase physical activity at all levels (83). 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 (83):

> 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).

[1] Estimate based on WHO-CHOICE analysis, available at: https://www.who.int/news-room/feature-stories/detail/new-cost-effectiveness-updates-from-who-choice (accessed 4 May 2022).

[2] 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" (83). 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* (37).

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) (95). 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 prepackaged 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" (96). 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 international reference for the safety and quality of food traded internationally (97).

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 (98). They also adopted the "Framework for Action", to contribute to ensuring accountability and monitoring progress in global nutrition targets (99). Recommendation 40 of the Framework for Action includes action to address childhood overweight and obesity, and a commitment to regulate the marketing of foods 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 …" (100).

4.5.4 Voluntary Guidelines on Food Systems and Nutrition, 2021

The UN Committee on World Food Security adopted the *Voluntary guidelines on food systems and nutrition* (VGFSyN) in February 2021 (101). The guidelines aim to support, inter alia, the development of coordinated, multisectoral 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 implementation of holistic, multisectoral, science and evidence-based and inclusive public policies …". They contain guiding principles that emphasize factors such as accountability, transparency and participation, and gender equality and women's empowerment.

Other important global policy developments that promote progress towards NCD prevention, healthy diets, nutrition, food systems and SDGs include the UN Food Systems Summit, held in September 2021 and the Tokyo Nutrition for Growth Summit, held in December 2021.

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 WHA has adopted strict guidance for WHO on engagement with non-State actors, including private sector actors and civil society (102). WHO has also developed specific guidance for addressing and managing conflicts in the planning and delivery of nutrition programmes (103).

NCD prevention and control measures often face resistance from industry players (104), 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 the effectiveness of proposed interventions, and proposing self-regulation rather than State regulation (105, 106). 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, countries in the WHO South-East Asia Region have faced several legal challenges (107); some of these have come from the tobacco industry on constitutional grounds. In Sri Lanka, tobacco companies challenged a clause of the tobacco control law that was intended to prohibit smoking in enclosed public places (108); the clause was put into place after observations about the harmful effects of passive smoking. The companies argued that the clause amounted to a restriction of the freedom to engage in a lawful trade, business or enterprise, since the companies' trade in alcohol and tobacco products was permitted by law. The Supreme Court held that the clause was constitutional and stated that a law could be validly enacted to protect public health by preventing exposure to tobacco smoke in enclosed public places (108). Similarly, while reviewing the constitutionality of a bill that mandated pictorial health warnings to cover 80% of each tobacco pack, the Supreme Court of Sri Lanka dismissed any objections raised by the intervening Ceylon Tobacco Company (109). The court noted that attending to public health was of high priority and that the size of pictorial warnings would not hinder tobacco companies' constitutional right to engage in lawful trade of tobacco products (109).

Box 5.1

EXAMPLES OF STRATEGIES EMPLOYED BY INDUSTRY TO FRUSTRATE REGULATION

Regulatory or other initiative	Industry tactic	Outcome
In 2017, the Thai Government introduced a tax on SSBs 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 (110).	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 (111).	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 (112).	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 (113).	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 (114).	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 in your country for implementing health-related 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 the 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 the national health, diet, nutrition, physical activity, and related policies in your country, identify at least three actions that your country could undertake to achieve the identified objectives.
7. Can you identify any policy gaps in your country's policies? 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. List the major government sectors that affect the promotion of healthy diets and physical activity, and describe their respective input.
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 Asia, is an LMIC. The country's 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) (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) (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 (115):
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) (b) promote healthy diets through population-wide policy measures such as taxation and regulation of markets; or
(c) (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 in 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

A human rights based approach: an introduction. Edinburgh: Scottish Human Rights Commission (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).

Human rights-based approach: statement of common understanding, State of the World's Children. New York: United Nations Children's Fund; 2004:90–3 (https://www.un-ilibrary.org/content/books/9789210597500s015-c003).

Non-communicable diseases (NCDs): the human rights factor. NCD Alliance; 2011 (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 (ed.), Global handbook on non-communicable diseases and health promotion. Atlanta: Springer New York, 3–19 (http://dx.doi.org/10.1007/978–1–4614–7594–1_1).

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/media/4w3bqxcj/putting_human_rights_at_heart_of_health_and_care.pdf).

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

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

Porsdam Mann S, Bradley VJ, Sahakian BJ. Human rights-based approaches to mental health: a review of programs. Health Hum Rights. 2016;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/publications/advancing-right-health-vital-role-law).

Garde A. Global health law and non-communicable disease prevention: maximizing opportunities by understanding constraints. In: Burci GL & Toebes B (eds.), Research handbook on global health law: Edward Elgar Publishing; 2018:389–426 (http://dx.doi.org/10.4337/9781785366543.00021).

Ó Cathaoir K, Hartlev M, Olsen C. 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; 2018:427–59 (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 South Asian region

PART C
SOUTH ASIAN REGIONAL CONTEXT

CHAPTER 6
REGIONAL LEGAL FRAMEWORK

6.1 Charter of the South Asian Association for Regional Cooperation

In 1985, the States of Bangladesh, Bhutan, India, Maldives, Nepal, Pakistan and Sri Lanka established the South Asian Association for Regional Cooperation (SAARC) through the Charter of the SAARC (116), with Afghanistan joining the group in 2007 (117). One of the main objectives of SAARC, as mentioned in Article I(a) of the Charter, is "to promote the welfare of the peoples of South Asia and to improve their quality of life". Article IV establishes a Council of Ministers, comprising the Foreign Ministers of the Member States, which is tasked with the preparation of the policies of the Association. Article VI can be harnessed for the prevention and control of NCDs. It establishes technical committees, comprising representatives of Member States, that are responsible for the implementation, coordination and monitoring of the programmes in their respective areas of cooperation such as health.

6.2 SAARC Social Charter

In 2005, SAARC Member States adopted a regional instrument called the Social Charter, which consolidated their various commitments in the social sector, and provided a practical platform for coherent action in determining social priorities and improving the content of social policies and programmes. One of the main aims of the Social Charter, as set out in Article IV(1), is "to protect and promote the health of the population in the region" (118). Another aim, as set out in Article VIII(1), is to develop national programmes through stakeholder partnership, with enhancement of allocation of requisite resources, to contribute to a positive atmosphere for the development of a "socially content, healthy and sustainable population in the region" (118). The implementation of the Social Charter is facilitated under Article X(1) by a National Coordination Committee or other national mechanism, as deemed appropriate by each State party. Information on national mechanisms is exchanged between States parties through the SAARC Secretariat. Bodies that have been deemed appropriate locally review the implementation of the Social Charter at the regional level.

Article X(2) can be harnessed for the implementation of policies aimed at preventing and controlling NCDs. It establishes the procedure to operationalize the provisions of the Social Charter, wherein Member States are expected to formulate national plans of action or modify existing plans in various areas of cooperation (e.g. environment, natural disasters, agricultural and rural development, poverty alleviation and health). Member States are expected to develop action plans through a transparent and broad-based participatory process, and to employ a stakeholder approach for the implementation and evaluation of the programmes under national plans of action.

6.3 SAARC Convention on regional arrangements for the promotion of child welfare in South Asia

Article IV of the SAARC Convention on Regional Arrangements for the Promotion of Child Welfare in South Asia recognizes basic services for children such as education and health care (119). It pays special attention to the prevention of diseases and malnutrition, and considers such prevention as the foundation of child survival and development. Article IV instructs States parties to pursue a policy of development and a national programme of action that facilitate the development of the child. The SAARC Convention can be harnessed for the prevention and control of NCDs in children, because it focuses on accelerating the progressive universalization of the child's access to the basic services and conditions (e.g. access to health care services, healthy and nutritional diets, and a healthy play environment).

CHAPTER 7
REGIONAL POLICY CONTEXT

7.1 Action plan for the prevention and control of noncommunicable diseases in South-East Asia 2013–2020

The WHO South-East Asia Regional Network for Prevention and Control of Noncommunicable Diseases was created in November 2005, to strengthen partnerships and regional cooperation among Member States for implementing policies and programmes for NCDs. The Action Plan for the Prevention and Control of Noncommunicable Diseases in South-East Asia (2013–2020) provides a blueprint for regional and national actions for developing and implementing policies and programmes to reduce the burden of NCDs within the regional socioeconomic, cultural, political and health system contexts (120). In relation to the promotion of physical activity and healthy diets, its aims include achieving a 10% relative reduction in the prevalence of insufficient physical activity and a 30% relative reduction in mean population intake of salt/sodium by 2025. In 2021, the WHO Regional Committee for South-East Asia decided to extend the Regional NCD Action Plan until 2030, taking into account the targets set for 2030 as part of the Agenda for Sustainable Development (SEA/RC74(2)).

7.2 New Delhi Declaration on High Blood Pressure

By adopting the New Delhi Declaration on High Blood Pressure in 2013, the health ministers from the WHO South-East Asia Region committed to prioritizing the prevention and control of high blood pressure and striving towards measurable reduction in the prevalence of hypertension in the region by 2025 (121). Through the declaration, the ministers of Member States committed to:

- undertake multisectoral collaboration with key stakeholders and empower people to make healthy choices for healthy lives;
- develop multisectoral policies to promote physical activity and healthy diet, and reduce exposure to tobacco and harmful use of alcohol;
- implement national salt reduction strategies, regulate the food industry (including food labelling) and reduce salt in processed foods;
- legislate for 100% tobacco smoke-free settings; and
- promote universal access to prevention, treatment and care for the integrated management of NCDs (including hypertension) through a primary health care approach.

7.3 Kathmandu Declaration

The 18th SAARC Summit was held in Nepal in 2014, during which the State heads of eight SAARC member countries along with their delegations signed a declaration towards deeper integration for peace and prosperity (122). This was the first time that SAARC had accepted NCDs as a major challenge to the health of the peoples of South Asia.

7.4 Colombo Declaration

The Member States of the WHO South-East Asia Region, through the 2016 Colombo Declaration, committed to strengthening their health systems to accelerate delivery of NCD services at the primary health care level (7). They agreed to do this by:

- strengthening and upscaling key components of comprehensive NCD management at the primary health care level, including health guidance and counselling to promote healthy choices and self-care; and
- taking a multisectoral approach to developing healthy public policies and population-based interventions for:
    * tobacco, alcohol, high intake of saturated fats/trans fats, sugar and salt, and increasing intake of fruits and vegetables; and
    * promotion of physical activity and non-sedentary behaviour and promotion of healthy behaviours in the general population and in key settings such as educational institutes (in particular through strengthening of school health programmes), workplaces and at community level.

CHAPTER 8 THE WAY FORWARD — STRATEGIES FROM THE SOUTH ASIAN 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 the rights discourse to wider public participation. For example, in Nepal, the Ministry of Health has collaborated closely with civil society in tobacco control, benefiting from technical expertise not only in developing laws and regulations (123) but also in defending those laws and regulations against industry-mounted court action (107). Many NGOs have been at the forefront of advocacy against tobacco use in South Asia. They have participated in drafting regulations that banned smoking in public places, directly lobbied for the passage of tobacco control legislation and the development of regulations under the legislation and trained public officials in the enforcement of those regulations (124).

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 public interest. In the case of *K. Ramakrishnan and Anr. v State of Kerala and Ors.* (125), two civil society actors filed a public interest litigation in Kerala (India) demanding a prohibition on smoking and the use of various forms of tobacco in public places. The Kerala High Court passed an order prohibiting tobacco smoking in public places in Kerala in 1999. The court relied on the constitutional right to life accorded in the Indian Constitution, which enabled tobacco smoking in public places to be positioned as a form of air pollution. Also in India, in 2013 the Supreme Court rejected a patent application for Novartis' cancer drug Glivec on the grounds that it was only a modified version of an existing drug. The decision is credited for having a significant impact on improving access to life-saving medicines in the developing world by demanding that patient needs supersede commercial interests (126). The precedents that affect access to 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 a 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 and related rights in the region. Although these cases do not all directly address NCDs, they are indicative of the willingness of courts to address health and related rights.

Box 8.1

EXAMPLES OF LITIGATION IN SOUTH ASIA TO ADDRESS HEALTH RIGHTS

Country	Case and determination	Comments
Sri Lanka	Sanjeewa, AAL (on behalf of G.M.Perera) v Suraweera, OIC, Wattala and others [2003] (127) An arrested man, while in police custody, was subject to mistreatment by the police, for which he was taken to the hospital. He sought compensation for his medical bills beyond any compensation for the mistreatment he endured. The Supreme Court of Sri Lanka allowed this compensation, stating that "citizens have the right to choose between State and private medical care" while citing Article 12 of the ICCPR. Justice Fernando reasoned that the infringement of a right to health can be justifiable under the Sri Lankan Constitution because the right to life would be meaningless without providing essential health care.	Right to health is not directly stipulated as a constitutional right in Sri Lanka. In this case, the right to life clause enabled the right to health.
India	Devika Biswas v Union of India and others [2016] (128) In this public interest litigation, a health rights activist challenged the State of Bihar Government's practice of subjecting mostly poor rural women to sterilization procedures in insanitary and dangerous sterilization camps. At these camps, informed consent was often not obtained from the patients. The Supreme Court found these practices to be in violation of women's right to health, and more specifically their reproductive rights, both of which are key components of the right to life under the Indian Constitution.	The Court referenced UNCESCR General Comment No. 22, which observes that reproductive health is an integral part of the right to health. It also noted the UN CEDAW's decision in *A.S. v Hungary*, which held that fully informed consent to sterilization is essential.
Bangladesh	Dr Mohiuddin Farooque v Bangladesh & Others [1995] (129) In some of the examinations conducted by various government testing bodies, powdered milk product that was imported by a company was found to contain radiation above the acceptable limit. The Bangladeshi Supreme Court upheld the claim of the petitioners that the actions of government officers, in not compelling the importer to send the consignment back to the exporter, had violated the constitutional right to life of people who were potential consumers. The court noted that "the right to life is not only limited to the protection of life and limbs but extends to the protection of health and strength of workers, their means of livelihood, enjoyment of pollution free water and air, bare necessities of life, facilities for education, development of children, maternity benefit, free movement, maintenance and improvement of public health by creating and sustaining conditions congenial to good health and ensuring quality of life consistent with human dignity." (129)	If right to life (including health) was threatened by a human-caused hazard, then the state could be compelled by the court to remove the threat (unless justified by law).
Sri Lanka	Bulankulama v. Sec'y, Ministry of Indus. Dev. [2000] (130) The Sri Lankan Government had called for proposals to establish a joint venture for the manufacture of phosphate fertilizer. The government accepted a proposal from a company from the USA. But in 1999, seven Sri Lankans filed a petition to stop the project on the ground of violation of their fundamental rights under the Constitution. Despite the claim that the government and not the court was the "trustee" of natural resources of Sri Lanka, the court considered the health impact of mining operations and granted relief to the petitioners on the grounds that there was an imminent infringement of the petitioners' fundamental rights under the Constitution.	Despite noting that a State has the right to exploit its own resources pursuant to its own environmental and development policies (Principle 21 of the UN Stockholm Declaration (1972) and Principle 2 of the UN Rio De Janeiro Declaration (1992)), the court observed that human beings are at the centre of concerns for sustainable development. They are entitled to a healthy and productive life in harmony with nature (Principle 1, Rio Declaration).

Pakistan	Pakistan: Shehla Zia and Ors v. WAPDA, PLD [1994] (131) In this case the petitioners, who were residents of a locality in Islamabad, filed a petition against The Pakistan Water Resources and Power Development Authority (WAPDA), which was to construct an electrical grid station in that area. The petitioners argued that the electromagnetic field created by the high voltage transmission lines would be hazardous to their health and that the designated green belt in that area would be destroyed. The government argued that the case was not maintainable because the petitioners had not cited any constitutional right that was infringed by the construction of the electrical grid. The court considered the case to be maintainable under Article 184 (3) of the Constitution, because the alleged health hazards and encroachment could be interpreted to violate the constitutional right to life when interpreted expansively.	The court observed that the government should adopt a precautionary approach akin to Principle 15 in the Rio Declaration.
Bangladesh	Nurul Islam v. Govt. of Bangladesh (Tobacco Advertising Case) [1999] (132) In this case the court heard two cases on tobacco advertising together. The first petition claimed that tobacco companies had not been following the law by printing statutory warnings on illegible corners of tobacco packets and that the tobacco advertisements in movie theatres were too brief to have any impact on viewers. The second case was about British American Tobacco using a touring luxury yacht to advertise its products. The High Court Division noted that young people were particularly affected by tobacco advertisements, which increased tobacco consumption. It then passed directions to ensure that the statutory warnings are noticeably and decipherably written on cigarette packets. The court, among other actions, directed the government to take steps towards restricting tobacco production and smoking in public. It also prohibited certain kinds of advertising and promotion of tobacco products.	This decision illustrates the scope of power exercised by the High Court under Article 102 of the Constitution to pass directions when fundamental rights are infringed. On a similar note, even though there is no bar on advertising of NABs for children in Bangladesh, this case establishes jurisprudence where the court relies on scientific evidence to take cognizance of the ill-effects of a substance such as tobacco.
India	People's Union for Civil Liberties (PUCL) v. Union of India & Ors. Writ Petition (Civil) No. 196 of 2001 and Interim Order of 2 May 2003 (133) Reading into Article 21 of the Constitution, which protects the right to life, the Indian Supreme Court derived a series of requirements articulating how various social programmes should be expanded and implemented, to ensure that the population (particularly the vulnerable strata of the society) is guaranteed a basic nutritional floor. The court built on eight schemes that included feeding programmes for infants, pregnant and nursing mothers, and adolescent girls (through the Integrated Child Development Services Scheme); midday school-meal programmes for school-age children; and subsidized cereals through a nationwide network of fair price shops (the Targeted Public Distribution Scheme).	This case dealt with the protection of right to food and prompted the development and adoption of the 2013 National Food Security Act.[1]

ICCPR: International Covenant on Civil and Political Rights; IDLO: International Development Law Organization; NAB: nonalcoholic beverage; UN: United Nations; UNCESCR: United Nations Committee on Economic, Social and Cultural Rights; USA: United States and America.

1 Further information on the importance of this case to fostering food security can be found in IDLO's 2015 report *Realizing the right to food: legal strategies and approaches* (134).

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 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 (135, 136); 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 South Asian 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 and related rights.

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

Mahipala P, Dorji G, Tisocki K, Rani M. A critical review of addressing cardiovascular and other non-communicable diseases through a primary health care approach in the South-East Asia Region. Cardiovasc Diagn Ther. 2019;9(2):150–7 (https://pubmed.ncbi.nlm.nih.gov/31143636/).

Isaranuwatchai W, Teerawattananon Y, Archer RA, Luz A, Sharma M, Rattanavipapong W et al. Prevention of non-communicable disease: best buys, wasted buys, and contestable buys. BMJ. 2020;368:m141 (https://www.bmj.com/content/368/bmj.m141).

Kaushik A, Peralta-Alvarez F, Gupta P, Bazo-Alvarez JC, Ofori S, Bobrow K et al. Assessing the policy landscape for salt reduction in South-East Asian and Latin American countries – an initiative towards developing an easily accessible, integrated, searchable online repository. Glob Heart. 2021;16(1):49 (https://pubmed.ncbi.nlm.nih.gov/34381671/).

Multisectoral coordination mechanisms and responses to noncommunicable diseases in South-East Asia: where are we in 2018? New Delhi: World Health Organization, Regional Office for South-East Asia; 2019 (https://apps.who.int/iris/handle/10665/326082).

Learning objectives:

- Explain the legal and policy measures taken by specific countries in the region to promote healthy diets and physical activity
- Recommend steps that can be taken to improve the law and fiscal policy, to effectively promote healthy diets and physical activity

PART D
SOUTH ASIAN SUBREGIONAL CONTEXT

CHAPTER 9
BANGLADESH

This chapter outlines the policy and legal framework that promotes healthy diets and physical activity in Bangladesh. Annex 3 provides further information on legislation related to food safety and labelling, consumer protection, value added tax and promotion of physical activity in Bangladesh. The material is drawn largely from desk reviews undertaken by WHO for Global RECAP.

Bangladesh is experiencing an increase in mortality from NCDs, with the proportion of NCD-related deaths increasing from 43.4% in 2000 to 60% in 2010 and 66.9% in 2015 (135). The total number of NCD-related deaths in 2016 amounted to over 572 600 (306 700 male, 265 900 female) (137). The trajectory of NCD mortality and morbidity in Bangladesh has presented a major threat to Bangladesh's existing health care systems, which are mainly geared towards addressing communicable diseases (138) (see A2.1 in Annex 2).

9.1 Legal and policy overview

9.1.1 Constitution of Bangladesh

The Constitution of Bangladesh provides an overarching framework to guide NCD prevention and control measures (139). The preamble states that it shall be the fundamental aim of the State to realize through the democratic process a socialist society, free from exploitation – a society in which the rule of law, fundamental human rights and freedom, equality, and justice, political, economic and social, will be secured for all citizens. Part II of the Constitution comprises the Fundamental Principles of State Policy, which serve as a guide for the interpretation of the Constitution and other laws of Bangladesh (Article 8(2)). It is the fundamental responsibility of the State to attain, through planned economic growth, a constant increase in productive forces and a steady improvement in the material and cultural standard of living of the people, with a view to securing to its citizens, inter alia, the provision of the basic necessities of life, including food, clothing, shelter, education and medical care (Article 15(1)). Article 18 of the Constitution states that the State shall regard raising the level of nutrition and improvement of public health as its primary duty. Further, it shall adopt effective measures to prevent the consumption of alcoholic and other intoxicating drinks and drugs that are injurious to health (except for medical purposes or for such other purposes as may be prescribed by law). Article 32 guarantees the right to life, wherein no person shall be deprived of life or personal liberty except in accordance with law. The Constitution also allows for the expansive reading of rights. For example, the Supreme Court has held that the protection of the health and normal longevity of an ordinary human being is an intrinsic aspect of the right to life (129).

9.1.2 Fourth Health, Population and Nutrition Sector Programmes 2017–2022

One of the targets of the Fourth Health, Population and Nutrition Sector Programme 2017–2022 (4th HPNSP) of the Government of Bangladesh is to increase consumption of fruits and vegetables and lower intake of saturated fats/trans fats, sugars and salt (140). The actions envisaged under the 4th HPNSP to achieve this target are:

- disseminate Bangladesh national dietary recommendations in mass media and through other channels;
- conduct public campaigns through mass media and social media to inform consumers about a healthy diet high in fruits and vegetables and low in saturated fat, sugar and salt;
- implement national salt reduction campaigns in mass media, schools and institutions;
- support consumer protection groups in Bangladesh to advocate against and discourage marketing of foods and NABs to children;
- promote nutritional labelling (e.g. accord-

ing to international standards, in particular the Codex Alimentarius) for all prepackaged foods including those for which nutrition or health claims are made; and
- impose high tax on energy drinks and beverages.

9.1.3 Second National Plan of Action for Nutrition 2016–2025

The Second National Plan of Action for Nutrition 2016–2015 (141) for Bangladesh includes the following indicators:

- increase the rate (>15 parts per million [ppm]) of iodized salt intake to 90%;
- control and reduce maternal overweight (body mass index [BMI] >23) to 30%; and
- no increase of childhood obesity (WHZ[1] ≥2) among children aged under 5 years.

9.1.4 Multi-Sectoral Action Plan for Prevention and Control of Non-Communicable Diseases 2018–2025

Bangladesh's Multi-sectoral Action Plan for Prevention and Control of NCDs 2018–2025 (142) includes the following actions for a healthy diet high in fruits and vegetables and with a low intake of saturated fats/trans fats, free sugars and salt:

- implementing national salt reduction campaigns in schools and institutions by increasing collaboration between salt (or sodium) reduction programmes and salt iodization;
- disseminating Bangladesh's national dietary recommendations through mass media and conducting public health campaigns to inform consumers about a healthy diet (a diet high in vegetables and fruits and low in saturated sugars, salt and fat);
- supporting consumer protection groups to discourage marketing of unhealthy foods and NABs to children and conducting counter advertisements to regulate the marketing of unhealthy foods, and banning the promotion and sponsorship of unhealthy diet; and
- promoting nutritional labelling for all prepackaged foods, but particularly for foods that make nutritional or health claims, and placing higher taxes on SSBs.

The plan includes the following actions to promote physical activity:

- adopting and advocating the national guideline on physical activity for health, encouraging town and urban planners to increase the number of public spaces to support physical activity and encouraging urban housing complexes to include safe spaces for walking and cycling;
- advocating for the formation of built and natural environments that support physical activity in universities, schools, workplaces and health facilities;
- developing policy measures to promote physical activity through the use of active transport, recreation, sports and leisure, and carrying out media campaigns and marketing to raise awareness of the benefits of engaging in physical activity; and
- making provisions for separate bicycle lanes and free and open spaces to inspire people to walk more and ensuring that existing footpaths are free from vendors.

The plan also includes the following actions to promote healthy behaviours in healthy and safe settings:

- enabling healthy programmes in schools and workplaces for promoting healthy activities;
- establishing health-promoting schools and a Healthy City Project, with strategies for implementation and apparatuses for monitoring and evaluation;
- establishing institutional supervision of young children (aged <5 years) through community day care centres, promoting playpens for children (aged <2 years) to reduce exposure to water bodies;

[1] The weight-for-height z score (WHZ) is a measure of body fat.

- conducting advocacy and training workshops that could help in promoting healthy behaviours in workplaces and schools; and
- discouraging the sale of processed foods that are high in harmful fats, sugars and salt in schools and workplace catering facilities.

9.1.5 Bangladesh Standard for the Labelling of Prepackaged Foods 2008

The Bangladesh Standard for the Labelling of Prepackaged Foods 2008 (143) applies to the labelling of all prepackaged foods to be offered for sale to consumers or for catering purposes, and to certain aspects relating to the presentation of these foods. According to the Standard, prepackaged food shall not be described or presented on any label or in any labelling in a manner that is false, misleading or deceptive, or is likely to create an erroneous impression regarding its character in any respect (e.g. labelling shall not create an erroneous impression regarding health benefits of the packaged food). Under the Standard, prepackaged food shall not be described or presented on any label or in any labelling by words, or pictorial or other devices that refer to or are suggestive (either directly or indirectly) of any other product with which such food might be confused, or in such a manner as to lead the purchaser or consumer to suppose the food is connected with such other product. Furthermore, it is mandatory to list the ingredients on the labels of prepackaged foods. See A3.1 in Annex 3 for details.

9.1.6 Food Saftey Act 2013

The Food Safety Act 2013 (144) prohibits people from manufacturing, distributing or selling any packaged food or unpackaged food ingredient that inscribes any false information or claim, or any mischievous or misleading information on the label concerning the food contained in the package or concerning the quantity or the nutritive value implying medicinal or therapeutic claims, or in relation to the place of origin of the said food. It also prohibits people from making, printing, publishing or propagating any advertisement containing false information as to the quality, nature, standard and so on of any article of food or food ingredient through which people may be misguided. The Act places the duty on food manufacturers, distributors and sellers to label food products with clear information about the production, packaging and expiry date of food and traceable information in the manner prescribed by food regulations. See A3.2 in Annex 3 for details.

Under Section 87, any authority with prior approval of the government may, by notification in the official Gazette, make regulations to carry out the purposes of this Act.

9.1.7 Food Safety (Labelling) Regulations 2017

The Food Safety (Labelling) Regulations 2017 (145) stipulate that the labels of packaged food products shall mandatorily contain nutritional information on energy value and the quantity of fat, saturates, salt, sugar and non-vegetarian content used. They prescribe that if salt is present in the food product only due to natural reasons, a declaration to that effect shall be made along with the nutritional information. See A3.3 in Annex 3 for details.

9.1.8 Consumers' Right Protection Act 2009

Section 44 of the Consumers' Right Protection Act 2009 (146) states that "If any person deceives any buyer by any false or untrue advertisement for the purpose of selling any goods or service, he shall be punished with imprisonment for a term not exceeding 1 (one) year, or with fine not exceeding Taka 2 (two) lacs, or with both". The Act also applies to foodstuffs, which are defined in Section 2 as "any article of food including fruits and drinks for the livelihood, nutrition and protection of health for human, fishes and livestock". See A3.4 in Annex 3 for details.

9.2 Fiscal Measures

9.2.1 Excises and Salt Act 1944

Duties are levied and collected on all excisable goods produced or manufactured in Bangladesh. They are levied at the rates set in the Excises and Salt Act 1944 (147). Under the Act, the National Board of Revenue has the authority to alter the tariff values. Section 3(3) stipulates that "different tariff values may be fixed for different classes or descriptions of the same article". Section 3A of the Act states that "the Government may through a notification in the official Gazette levy a regulatory duty on any excisable goods or services, in addition to the base duty stipulated under Section 3 of the Act". The rate imposed under Section 3A cannot exceed 100% of the rate that is specified under Section 3, and in the case of excisable goods, the rate cannot exceed 30% ad valorem, or 25% of the retail price. The production or manufacture of any specified excisable goods (e.g. tobacco, alcohol and SSBs) can be undertaken only in accordance with the terms and conditions of the licence granted under Section 6 of the Act. The Board, for the purposes of the Act, may appoint excise officers and any excise officer duly empowered by the Board may arrest any person whom the officer has reason to believe is liable to punishment (Section 13).

9.2.2 Value Added Tax and Supplementary Duty Act 2012

Bangladesh imposes supplementary duty on soft drinks; the provisions for this are included under the Value Added Tax and Supplementary Duty Act 2012 (148) (which repealed the Value Added Tax Act 1991 (149)). Section 55 of the Act states that "supplementary duty shall be imposable and payable on the import of goods and on the supply of goods manufactured in Bangladesh". This duty is not imposed if the goods are not for home consumption, only if they are imported for export. Under Section 56 of the Act, persons liable to pay supplementary duty are the importer (in the case of import of goods that are subject to supplementary duty), and the supplier (in the case of supply of goods that are manufactured in Bangladesh and subject to supplementary duty).

Domestically produced SSBs are taxed by two general taxes:

- A value added tax (VAT) at a single rate of 15% is levied on most goods (including all foods and beverages). The tax base for VAT is the net value added at every stage of the production or commercialization of the product.
- A supplementary duty (SD) is also levied on most goods. The tax rate differs according to the good. The SD for energy drinks is 35%, for domestically produced SSBs it is 25% and for imported SSBs it is 150%. See A3.5 in Annex 3 for details.

9.3 Further reading

Biswas T, Pervin S, Tanim MIA, Niessen L, Islam A. Bangladesh policy on prevention and control of non-communicable diseases: a policy analysis. BMC Public Health. 2017;17(1):582 (https://pubmed.ncbi.nlm.nih.gov/28629430/).

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Khan A, Burton NW, Trost SG. Patterns and correlates of physical activity in adolescents in Dhaka city, Bangladesh. Public Health. 2017;145:75–82 (https://www.sciencedirect.com/science/article/pii/S0033350616304255).

CHAPTER 10
SRI LANKA

This chapter outlines Sri Lanka's legal framework, policies and fiscal measures that promote healthy diets and physical activity. Annex 4 provides further information on regulation of food marketing, labelling and formulation of food products, consumer protection, the Excise Act and promotion of physical activity in Sri Lanka. The material is drawn largely from desk reviews undertaken by WHO for Global RECAP.

Rapid demographic transition underlined by shifting lifestyles has affected healthy diets and physical activity in Sri Lanka. About 83% of total deaths are NCD-related deaths, with cardiovascular diseases contributing a major share (137). In adults, physical inactivity is more prevalent among females (at 37.4%) than among males (at 20.5%); however, in adolescents the numbers are much higher, being 88.7% in females and 81.6% in males (see A2.2 in Annex 2).

10.1 Legal and policy overview

10.1.1 Constitution of Sri Lanka

The Constitution of Sri Lanka (150) does not expressly guarantee rights to health or food. The Directive Principles of State Policy and Fundamental Duties (Article 27), which are envisioned to guide the Parliament, President, and the Cabinet of Ministers in the enactment of laws and the governance of Sri Lanka, include the following objectives:

- "The realization by all citizens of an adequate standard of living for themselves and their families, including adequate food" (Art. 27(2)(c)).
- "The rapid development of the whole country by means of public and private economic activity and by laws prescribing such planning and controls as may be expedient for directing and coordinating such public and private economic activity towards social objectives and the public welfare" (Art. 27(2)(d)).
- Promotion of "with special care the interests of children and youth, to ensure their full development, physical, mental, moral, religious, and social, and to protect them from exploitation and discrimination" (Art. 27(13)).

The Constitution states that these principles are not enforceable in any court or tribunal.

10.1.2 Multisector Action Plan for the Prevention and Control of Non-Communicable Diseases 2016–2020

The national Multisector Action Plan for the Prevention and Control of Non-Communicable Diseases 2016–2020 (151) included strategies for developing mechanisms, policies and methods to:

- promote a healthy diet high in fruits and vegetables and low in saturated fat/*trans* fat, free sugar and salt;
- increase the availability of healthy foods, including foods low in salt, sugar and fats;
- take measures to reduce *trans* fat in processed foods;
- introduce food labelling to indicate unhealthy foods;
- increase tax for unhealthy food;
- promote maternal and child nutrition;
- improve availability of healthy foods;
- conduct awareness programmes on healthy foods and food-based dietary guidelines; and
- improve obesity management.

10.1.3 Guidelines for the establishment of healthy lifestyle centres in healtcare institutions 2011

The *Guideline for the establishment of healthy lifestyle centers in healthcare institutions 2011* (152) stipulates that the Provincial Directors of Health Services must ensure the establishment and functioning of healthy lifestyle centres for screening of NCDs through the Regional Director of Health Services by facilitating the medical officers of NCDs.

The guidelines for screening and evaluation include:

- making any person (ideally aged between 40 and 65 years) who is previously undiagnosed with an NCD an eligible candidate for screening;
- undertaking assessment and relevant intervention in case of risk behaviours such as unhealthy diet, smoking, physical inactivity and alcohol consumption; and
- monitoring and evaluation of the programme at the relevant district and national levels.

Challenges to the establishment and functioning of healthy lifestyle centres include a lack of or weak adherence to protocols by the staff, underuse of services provided by the centres, a lack of integration into the already existing NCD screening services in the country, and problems related to human resources (152, 153).

10.1.4 Physical Activity and Sedentary Behaviour Guidelines for Sri Lanka 2018

The Physical Activity and Sedentary Behaviour Guidelines for Sri Lanka 2018 (154) are mostly intended for those aged between 5 and 64 years. They specify the intensity and duration of physical activity that are required by each age group to stay healthy. The guidelines define health-enhancing physical activities such as jumping rope, yoga, dancing, brisk walking, climbing on playground equipment and lifting weights.

10.1.5 National Sports Policy of Sri Lanka 2012

The National Sports Policy of Sri Lanka 2012 (155) aims to build a disciplined, healthy, unified and prosperous society. It encourages the implementation of better physical health programmes that would cover all aspects of the society.

10.1.6 National Nutrition Policy of Sri Lanka 2010

The National Nutrition Policy of Sri Lanka 2010 (156) recognizes the impact of advertising, convenience and peer pressure that can lead to unbalanced and unhealthy dietary patterns. It recognizes sedentary lifestyles, imbalanced diets and a general lack of physical activity as major risk factors that lead to a high prevalence of obesity and other diet-related NCDs. The policy states that appropriate nutrition should be promoted for adults and older people to ensure the prevention and control of nutrition-related NCDs (policy statement 5.1.6).

10.1.7 Policy – Health Canteen in Work Places 2013 and Circular 2015

The Policy – Healthy Canteen in Workplaces 2013 (157) and healthy canteen circular 2015 (158) acknowledge the important role played by canteens at workplaces for serving nutritious, healthy and balanced food that can encourage workers to make healthier food choices. The policy recommends that canteen meals comprise a variety of foods with fresh fruits and at least one protein-rich food for each main meal. It also recommends that liquid milk and milk products be made available in canteens, and that foods and drinks be prepared with limited refined sugar.

10.1.8 National Salt Reduction Strategy (2018–2022)

The National Salt Reduction Strategy 2018–2022 (159) includes a comprehensive action plan to reduce salt intake among adults to 8 g or less per day by 2025. The national action plan includes a mandatory activity to reduce the salt content of commonly consumed industrially processed foods, such as salted snacks, through product reformulation.

10.1.9 Food Act 1980

The Food Act 1980 (160) regulates and controls the manufacture, importation, sale and distribution of food. Section 3 of the Act states that "No person shall label, package, treat, process, sell or advertise any food in a manner that is false, misleading, deceptive or likely to create an erroneous impression, regarding its character, value, quality, composition, merit or safety". The Act prohibits advertising food as healthy, if it is in fact poorly nutritious. Section 4 states that "Where a standard is prescribed for any food, no person shall label, package, sell or advertise any food which does not conform to that standard in such a manner as is likely to be mistaken for the food for which the standard has been prescribed". It is helpful to read this provision along with any regulations that regulate sweeteners or unhealthy food.

All food-related regulations are published under Section 32 of the Act, which empowers the Minister of Health, after consultation with the Food Advisory Committee, to make regulations related to packaging, labelling, exposing, offering, and advertising for sale of food. In 2022, new food regulations were adopted on trans-fat, labelling, advertising, and color-coding for sugar levels in liquids. See A4.1 in Annex 4 for details.

10.1.10 Food (Labelling and Advertising) Regulations 2022

The Food (Labelling and Advertising) Regulations 2022 (161) requires that the package or container of food shall be labelled clearly and conspicuously and sets the specifications to ensure that food labelling is clear, legible and accurate. It states that no food shall be described or presented in a manner that is false, misleading, or deceptive, or is likely to create an erroneous impression regarding its character in any respect (Regulation 12). It further states that no label or advertisement relating to any food shall contain a false claim or misleading description in such a manner as to mislead consumers (Regulation 11). The Regulations also include provisions on nutrition claims and health claims, ensuring that they are in accordance with approved standards and/or approved by the competent authority.

10.1.11 Food (Trans-Fat) Regulations 2022

The Food (Trans-Fat) Regulations 2022 (162) adopts mandatory limits that restrict industrially produced trans-fat to maximum two percent of total fat contained in the food. It also imposes a ban on partially hydrogenated oils in food products. The regulations also stipulate that the amount of *trans* fat contained in food products shall be declared on the label of such packaged food.

10.1.12 The Food (Colour Coding for Sugar Levels- Liquid) Regulations 2022

The Food (Colour Coding for Sugar Levels - Liquid) Regulations 2022 (163) implement a symbolic system for the front-of-pack labelling for various categories of SSBs. They require that the products covered under the regulations display a label on their packaging that includes a logo with the description of the sugar content for the drink in three languages (Sinhala, Tamil and English). The logo shall include a numerical description of the sugar values, combined with a colour-coded display in red, amber, and green.

10.1.13 Food (Adoption of Standards) Regulations 2008

The Food (Adoption of Standards) Regulations 2008 (164) allow content to be regulated through the development and publication of standards setting thresholds for sugars, salt and fats in categories of staple products. The Sri Lanka Standards Institution (SLSI) was established under the Sri Lanka Standards Institution Act 1984, which also provides SLSI with the power to formulate standards on a national and international basis relating to commodities such as food products and to promote standardization and quality control in industry. SLSI has a product certification system in place, which means that whenever an SLSI mark is applied to a product, the product shows sufficient quality to meet its standards. Currently, the SLSI mark is mandatory for seven food categories including fruit beverages, preprepared drinks and synthetic cordials. Manufacturers of food products aiming to adopt the SLSI mark need to comply with labelling and marketing standards and regulations, and they also need to provide samples for regular scientific testing (at their own cost). As a member

of the Food Advisory Committee, SLSI is also involved in developing food-related regulations. If manufacturers use the SLSI marks improperly, the SLSI has the authority to cancel licenses as penalty.

10.1.14 Consumer Protection Act 1979

The Consumer Protection Act 1979 (165) aims to protect consumer interests. It allows the Commissioner of Internal Trade to issue general directions to manufacturers or traders in respect of labelling, price-marking and packaging of any article. Any manufacturer or trader who fails to comply with any direction issued by the Commissioner shall be guilty of an offence under this Act. Further, any person who removes, alters, obliterates, erases or defaces any label, description or price marked on any article shall be guilty of an offence under Section 6 of the Act. Any trader who represents that goods or services have sponsorship, approval, performance, characteristic accessories, uses or benefits they do not have will be guilty of an offence under Section 19 of the Act. See A4.3 in Annex 4 for details.

10.2 Fiscal measures

10.2.1 Excise (Special Provisions) Act 1989

TThe Excise (Special Provisions) Act 1989 (166) mandates that "an excise duty shall be charged, levied, and paid on every article manufactured or produced in Sri Lanka, or imported into Sri Lanka. The rate of excise duty may be varied by an Order passed by the Minister of Finance" (Section 3). A Director-General of Excise along with other excise officers are responsible for the implementation of the provisions of the Act (Section 2). The excise duties on products relevant to preventing NCDs are contained in a 2017 Order passed by the Minister of Finance under Section 3 (167), the details of which can be found in A4.4 in Annex 4.

10.3 Further Reading

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10.4 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 Bangladesh and Sri Lanka reflect gendered patterns, particularly in the context of healthy diets 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 does your country have 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 two countries covered in this toolkit – Bangladesh and Sri Lanka – cooperate and implement policies under the SAARC Social Charter?

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ANNEX 1
Additional Exercises

A1.1 Preparation of a comprehensive brief for Bangladesh

The Minister of Health has decided to seek Cabinet approval for the drafting of a comprehensive bill to minimize the incidence of noncommunicable diseases (NCDs). You have been asked to prepare a comprehensive brief of 1000–1500 words addressing the following matters:

- the incidence of NCDs and trends in recent years in Bangladesh and in selected South Asian countries;
- limitations of current policy instruments, institutional mechanisms and applicable legislation;
- how a rights-based approach can be used to develop the content of the bill;
- possible objections you envisage from affected industries and interest groups; and
- basic elements to be covered in the bill.

A1.2 Preparation of a comprehensive brief for Sri Lanka

The Minister of Health has decided to seek Cabinet approval for the drafting of a comprehensive bill to minimize the incidence of NCDs. You have been asked to prepare a comprehensive brief of 1000–1500 words addressing the following matters:

- the incidence of NCDs and trends in recent years in Sri Lanka and in selected South Asian countries;
- limitations of current policy instruments, institutional mechanisms and applicable legislation;
- how a rights-based approach can be used to develop the content of the bill;
- possible objections you envisage from affected industries and interest groups; and
- basic elements to be covered in the bill.

A1.3 Right to health and NCDs: 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, if any, pertaining to NCDs? How might a future submission correct these gaps?
For Bangladesh, see pages 72–77 of the Alternative Report to the United Nations Committee on Economic, Social and Cultural Rights (1).
For Sri Lanka, see pages 44–48 of the Joint Civil Society Shadow Report to the United Nations Committee on Economic, Social and Cultural Rights (2).

A1.4 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 the 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?

A1.5 Scenario 2

The government is considering introducing specific taxation on sugar-sweetened beverages (SSBs) as a strategy to reduce their consumption. A delegation of small traders approaches 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 SSBs 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?

A1.6 Scenario 3

The government plans to introduce legislation to restrict the advertising of fast foods and SSBs 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

1. Economic, social and cultural rights in Bangladesh: an alternative report to the United Nations Committee on Economic, Social and Cultural Rights. Dhaka: Human Rights Forum Bangladesh; 2018.
2. The state of economic, social and cultural rights in Sri Lanka: a joint civil society shadow report to the United Nations Committee on Economic Social and Cultural Rights. 2017.

ANNEX 2
Noncommunicable Disease Data for Country Profiles

A2.1 Bangladesh NCD profile

Mortality data (2016 data) (1)

- **Total number of NCD-related deaths: est. 572 600 (estimated 306 700 males, 265 900 females)**
- **Percentage of NCD-related deaths out of total deaths: 66.9%**
- **Number of NCD-related deaths aged under 70 years: 2913**

Proportional mortality (2016 data) (1)

- **CVDs: 30.1% (age-standardized death rate for CVDs/100 000: males – 246.1, females – 229.2)**
- **Cancers: 11.6% (age-standardized death rate for cancers/100 000: males – 95.4, females – 73.2)**
- **Diabetes: 3.3% (age-standardized death rate for diabetes/100 000: males – 21.8, females – 30.3)**
- **CRDs: 9.6% (age-standardized death rate for CRDs/100 000: males – 90.4, females – 65.4)**
- **Other NCDs: 12.3%**
- **Risk of premature death from four target NCDs: 21.6% (males – 22.6%, females – 20.4%)**

Risk factors (2)

- **Raised blood glucose: 8.3% (males – 8.9%, females – 7.9%)**
- **Obesity: 5.4% (males – 2.3%, females – 8.6%)**
- **Raised blood pressure: 21% (males – 17.9%, females – 24.1%)**
- **Raised blood cholesterol: 28.4% (males – 27.4%, females – 29.3%)**
- **Insufficient physical activity: 12.3% (males – 9.6%, females – 14.8%); highest prevalence in females aged 55–69 = 36.6%**

Nutrition Status (3)

- **Child malnutrition – overweight (BMI for age >+1 SD) in school-age children and adolescents aged 5–19 years: 9%**
- **Food security:**
  - **Households consuming adequately iodized salt (15 ppm or more): 69%**
  - **Population below minimum level of dietary energy requirement (undernourishment): 16.4%**
  - **Population below the international poverty line: 18.5%**
- **Caring practices:**
  - **Initiation of breastfeeding within 1 hour of birth: 50.8%**
  - **Introduction to solid, semisolid or soft foods in infants aged 6–8 months: 64.7%**
  - **Minimum acceptable diet in children aged 6–23 months: 22.8%**
  - **Children with diarrhoea aged <5 years receiving oral rehydration therapy and continued feeding: 66%**
- **Commitment**

[1] The information provided in Annex 2 builds on the desk reviews conducted by WHO under the Global RECAP Programme. WHO Legal and Regulatory Mapping: Bangladesh, 22 April 2020; Sri Lanka, 17 February 2021 (internal documents).

Indicator	Year	Value
General government expenditure on health as % of total government expenditure	2019	4.9%
National governance score	2009	Strong
International Code on Marketing of Breast milk Substitutes Legal status of the Code	2016	Several provisions included in the law

Diet (2) – Fruit and vegetable consumption

Description	Both sexes	Males	Females
Average servings of fruits and vegetables consumed per day	2.6	2.5	2.7
Inadequate intake of fruits and/or vegetables (<5 servings per day)	89.6%	90%	89.3%

Additional data (4)

Nutrition country profile: four indicators towards global nutrition targets where no progress has been made include:

- Under-5 overweight: no progress
- Adult male obesity: no progress or worsening
- Adult female diabetes: no progress or worsening
- Adult male diabetes: no progress or worsening.

Based on GHO data, the increase in prevalence of overweight and obesity in Bangladesh is staggering. In adults, the age-standardized prevalence of overweight increased from 4.6% in 1975 to 20% in 2016 (more than four times). Similarly, estimates of age-standardized prevalence of obesity among adults increased from 0.2% in 1975 to 3.6% in 2016, a 17-fold increase (annual average growth rate of 7.1%). The STEPS survey carried out in 2018 estimated that, among adults in Bangladesh, currently 20.3% are overweight and 5.4% are obese, which is consistent with the above-mentioned estimates. Among children and young people aged 5–19 years, the increase in overweight prevalence was greater – from 0.3% in 1975 to 9% in 2016. This represented a 29-fold increase or an annual average growth in prevalence of 8.6%. In Bangladesh, child obesity prevalence increased from 0 in 1975 to 2.6% in 2016.

BMI: body mass index; CRD: chronic respiratory disease; CVD: cardiovascular disease; GHO: Global Health Observatory; NCD: noncommunicable disease; ppm: parts per million; SD: standard deviation; STEPS: STEPwise approach to NCD risk factor surveillance.

A2.2 Sri Lanka NCD profile

Mortality data (2016 estimates) (1)

- **Total number of NCD-related deaths: est. 118 700 (estimated 62 600 males, 56 100 females)**
- **Percentage of NCD-related deaths out of total deaths: 83%**
- **Number of NCD-related deaths aged under 70 years: 53 031 (estimated 33 494 males, 19 537 females)**
- **Percentage of premature (aged 30–70 years) NCD-related deaths:**
  - **as a percentage of total deaths: 37%**
  - **as a percentage of total NCD-related deaths: 45%**
- **Probability of dying between the ages of 30 and 70 years from four main NCDs: 17.4%**

Proportional mortality estimates (2016 estimates) (1)

- **CVDs: 33.9% (age-standardized death rate for CVDs/100 000: males – 258.8, females – 169.7)**
- **Cancers: 14.2% (age-standardized death rate for cancers/100 000: males – 101.8, females – 74.7)**
- **Diabetes: 8.6% (age-standardized death rate for diabetes/100 000: males – 53.5, females – 52.7)**
- **CRDs: 8.2% (age-standardized death rate for CRDs/100 000: males – 62.4, females – 42.7)**
- **Other NCDs: 17.8%**

Risk factors (1)

- **Raised blood glucose (2014): 7.4% (males – 7%, females – 7.7%)**
- **Obesity (BMI ≥30 kg/m2) (2016): 5.4% (males – 3%, females – 7.7%)**
- **Overweight (BMI ≥25 kg/m2) (2016): 24.2% (males – 19.2%, females – 28.7%)**
- **Raised blood pressure (2015): 22.4% (males – 23%, females – 21.6%)**
- **Physical inactivity (2016):**
  - **Adults (crude rate): 28.9% (males – 20.5%, females – 37.4%)**
  - **Adolescents (crude rate): 85.2% (males – 81.6%, females – 88.7%)**

Nutrition status (5, 6)

- **Child malnutrition**
  - **Overweight (BMI for age >+1 SD) in school-age children and adolescents aged 5–19 years: 12.9%**
- **Food security**
  - **Households consuming adequately iodized salt (15 ppm or more): 95.2%**
  - **Population below minimum level of dietary energy requirement (undernourishment): 22%**
  - **Population below the international poverty line: 1.9%**
- **Caring practices:**
  - **nitiation of breastfeeding within 1 hour of birth (2016): 90.3%**
  - **Introduction to solid, semisolid or soft foods in infants aged 6–8 months (2016): 88%**
  - **Minimum acceptable diet in children aged 6–23 months: no data**
  - **Children with diarrhoea aged <5 years receiving oral rehydration therapy and continued feeding (2016): 63.1%**

- **Commitment**

Indicator	Year	Value
General government expenditure on health as % of total government expenditure	2016	8.56%
National governance score	–	–
International Code on Marketing of Breast-milk Substitutes – Legal status of the Code	2016	Provisions in law, currently under review and revision

- **Capacity**

Indicator	Year	Value
Degree training in nutrition exists	2016–2017	Yes
Nutrition is part of medical curricula	2016–2017	Yes
Nutrition professionals density (per 100 000)	2016–2017	0.2
Low-income food deficit country	2016	No

Diet (5) – Fruits and vegetables consumed (2015)

Description	Both sexes	Males	Females
Mean number of days fruit consumed in a typical week	3.6	3.5	3.8
Mean number of servings of fruit consumed on average per day	1.3	1.3	1.3
Mean number of days vegetables consumed in a typical week	6.6	6.5	6.6
Mean number of servings of vegetables consumed on average per day	3	3	3.1
Percentage who ate <5 servings of fruit and/or vegetables on average per day	72.5	73.1	72

Additional data (6)

Nutrition country profile: four indicators towards global nutrition targets where no progress has been made include:

- Under-5 overweight: no progress or worsening (WHO country office information suggests no significant change since last assessment)
- Adult female obesity: no progress or worsening
- Adult male obesity: no progress or worsening
- Adult female diabetes: no progress or worsening
- Adult male diabetes: no progress or worsening.

BMI: body mass index; CRD: chronic respiratory disease; CVD: cardiovascular disease; NCD: noncommunicable disease; ppm: parts per million; SD: standard deviation; WHO: World Health Organization.

Other reports relevant to this annex are those from the World Bank and Global Nutrition Report (7, 8).

References for Annex 2

1 Global Health Observatory data repository: total NCD mortality, data by country [website]. Geneva: World Health Organization; 2022 (https://apps.who.int/gho/data/node.main.A860?lang=en).

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ANNEX 3
Bangladesh Food Safety and Labelling, Consumer Protection, Value Added Tax, and Promotion of Physical Activity

A3.1 Bangladesh Standard for the Labelling of Prepackaged Foods 2008 (1, 2)

Title	Relevant provision
Definition clause	
Claim	Any representation which states, suggests, or implies that a food has particular qualities relating to its origin, nutritional properties, nature, processing, composition, or any other quality.
Consumer	Persons and families purchasing and receiving food in order to meet their personal needs.
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 or tobacco or substances used only as drugs.
Label	Any tag, brand, mark, pictorial, or other descriptive matter, written, printed, stenciled, marked, embossed, or impressed on, or attached to, a container of food.
Labelling	Any written, printed, or graphic matter that is present on the label, accompanies the food, or is displayed near the food, including that for the purpose of promoting its sale or disposal.
Prepackaged	Packaged or made up in advance in a container, ready for offer to the consumer, or for catering purposes.
Foods for catering purposes	Those foods for use in restaurants, canteens, schools, hospitals, and similar institutions where food is offered for immediate consumption.
General principles	Prepackaged food shall not be described or presented on any label or in any labelling in a manner that is false, misleading, or deceptive or is likely to create an erroneous impression regarding its character in any respect. Prepackaged food shall not be described or presented on any label or in any labelling by words, pictorial or other devices which refer to or are suggestive either directly or indirectly, of any other product with which such food might be confused, or in such a manner as to lead the purchaser or consumer to suppose the food is connected with such other product.
Mandatory labelling of prepackaged foods	• Name of the food • List of ingredients • Net contents and drained weight • Name and address • Country of origin • Lot identification • Date marking and storage instructions • Instructions for use

A3.2 The Food Safety Act 2013 (3)

Title	Relevant provision
Definition clause (Section 2)	
Food	Any edible substance, whether processed, partially processed, or unprocessed, which are edible by chewing, sucking, or licking (such as food grains, pulses, fish, meat, milk, eggs, edible oil, fruits, vegetables, etc.) or by drinking (such as normal water, aerated water, carbonated water, energy drink etc.).
Misbranded food	Any article of food or food ingredient which is produced, imported, manufactured, or labelled in an unlawful manner resembling any other lawfully marketed article of food or food ingredient on sale, whether the element, ingredient, purity, or quality of such lawful food is present in it or not.[1]
Institutional Structure of Food Safety System (Chapter II): National Food Safety Management Advisory Council (Section 3)	The National Food Safety Management Advisory Council shall provide necessary advice and direction to the Authority to formulate policy and plan on food safety system. The composition of the Council shall be as described in Section 3.
Bangladesh Food Safety Authority (Section 5)	The Authority shall be a body corporate having perpetual succession and a common seal.
Labelling Duties and functions of the Authority (Section 13)	The Authority shall be a body corporate having perpetual succession and a common seal. The main duties and functions of the Authority shall be to regulate and monitor the activities related to manufacture, import, processing, storage, distribution, and sale of food so as to ensure access to safe food through exercise of appropriate scientific methods, and to coordinate the activities of all the organizations concerned with food safety management. Most importantly the duty that is relevant for RECAP is that the Authority shall prescribe the procedure relating to packaging and expressing claims on health, nutrition, special dietary uses and categorization of packaged food. Further the Authority is empowered to issue directives related to food safety and quality to any authority, organization or person concerned directly or indirectly with food safety management (Section 19). For efficient performance of the duties, the Authority is organized into five divisions: -Food Safety Surveillance and Adjudication Affairs; -Food Safety Laboratory Network Coordination Affairs; -Food Safety Standardization Coordination Affairs; -Consumers' Concerns, Food Safety, and risk Management; and -Establishment, Finance, Human Resource and Corporate Affairs of the Bangladesh Food Safety Authority.
Food Safety Management Coordination Committee (Section 15)	To coordinate amongst all authorities or organizations involved directly or indirectly in food safety management system, the Act envisages a Coordination Committee. The objective of the Coordination Committee is to ensure necessary institutional support from relevant authorities or organizations for successful performance of the duties and functions assigned to the Authority under this Act.

[1] Bangladesh has separate provisions for food adulteration (Sec. 272-3 of the Penal Code 1860) and for the conduct of the food market (Sec. 6 of the Control of Essential Commodities Act 1956). Although they are not directly relevant to the *promotion* of healthy diets, they indicate high consideration for food security as directly linked to the public health function.

Food packaging and labelling (Section 32)	No person shall, directly or indirectly, by himself or by any other person acting on his behalf: (a) manufacture, distribute or sell any packaged food or food ingredient which is not packaged, marked, and labelled in such manner as may be prescribed by regulations or any other law for the time being in force; (b) inscribe any false information or claim, or any mischieving or misleading information on the label mentioned in clause (a) concerning the food contained in the package or concerning the quantity or the nutritive value implying medicinal or therapeutic claims or in relation to the place of origin of the said food; (c) manufacture, distribute or sell any packaged food or food ingredient without complying with the obligation of labelling it with a representation of clear information about the production, packaging and expiry date of food and traceability information in the manner prescribed by regulations; and (d) sell any packaged food or food ingredient by changing or erasing any information inscribed on the label of the packaged food product or food ingredient.
False or misleading information in advertisement (Section 41)	No person shall, with the intention of marketing or selling any article of food or food ingredient, cause harm to any consumer by giving any false or misleading information or statement in contravention of the conditions for advertisement prescribed by regulations.
Making, printing, or propagating of false advertisement (Section 42)	1. No person shall make, print, publish or propagate any advertisement containing false information as to quality, nature, standard etc. of any article of food or food ingredient through which people may be misguided. 2. In a suit filed under this section, the defendant, for defending himself, shall have to prove that: (a) he was not aware of such false advertisement, or he has not come to know despite due diligence; and (b) he, as a maker, printer, publisher, or propagator has made, printed, published or propagated the advertisement in usual course of business. 3. Where any complaint is lodged against any person under this section in any court, the court shall, unless otherwise proved, presume that such manufacturer or seller has made the endeavor or rendered the assistance to, print, publish or propagate such advertisement.
Inspection under the Act (Chapter VIII)	The Authority shall appoint such numbers of Food Safety Inspectors, as may be necessary, for discharging the duties assigned to them under this Act. The inspector is authorized to enter into any food establishment, building or house at any time to ascertain whether anything is being carried out in violation of any provision of this Act.
Food Court, Complaint, Trial etc. (Chapter X)	The Government in consultation with the Supreme Court may designate any court of 1st Class Magistrate, in the Metropolitan area as Pure Food Court. The trial of an offence under this Act shall generally be held by the Food Court within whose local jurisdiction the offence is committed.
Complaint and case filing (Section 66)	Any person, including food purchaser, consumer, food receiver or user, may lodge a complaint in writing to the Chairman or any person authorized by him in this behalf or an Inspector, in respect of any anti-food safety practice under this Act. After being informed of an offence under this Act, the Chairman or the person authorized by him in this behalf or the Inspector, if primarily be confirmed about the commission of such offence after making necessary inquiry or investigation, shall file a case before the Food Court.
Civil remedies (Chapter XI)	There shall be no legal bar for any affected person or food consumer to institute a civil suit in a competent court claiming civil remedies against a person who is prosecuted for any activity against this Act and convicted of any criminal offence committed thereby.
Power to make regulations (Section 87)	The Authority, with prior approval of the Government, may, by notification in the official Gazette, make regulations to carry out the purposes of this Act.

A3.3 Food Safety (Labelling) Regulations 2017 (4)

Title	Relevant provision
Definition clause (Regulation 2)	
Package	A protective or covering mechanism provided to a product like a case, box, carton, packet, sachet, wrapper, sack-pack, liquid-carrying vessel, bottle, container, can, band, reel, frame, cone, capsule, lid, and such other articles.
Packaged food	It shall mean those food products which have been presented to the consumer or supplier in pre-packaged form.
Label	It shall mean easily noticeable marks identifying the product which may be inscribed on the package, like a tag, brand-name, mark, pictorial description, hallmark, graphics, descriptive instructions etc. in hand-written, printed, and stamped form or stenciled, embossed or printed with indelible ink through a computerized process or conventional printing methods.
Labelling	Those descriptions in hand-written, printed or graphics form, which identify the product and are displayed on the label.
Labelling (Chapter 2)	1. For packaged food products, the following general conditions are to be complied with: a. In the case of packaged food products produced within the country, the information about the said product provided on the label must be in the Bengali language; however, if required, the said information may be provided alongside in one or more foreign languages. b. For imported packaged food products, if the label is provided in a foreign language, the same must also be translated into the Bengali language and displayed either on the original label or in a sub-label for this purpose. c. The label of the packaged food product must contain the required information about the product and its ingredients, either in the container or in the packaging itself. d. For the benefit of the consumer, the label must clearly display detailed information as regards the name of the product and the list of ingredients used in simple words, as far as possible. e. The label should be prominently displayed and must be clear and easily legible/readable and, adhering to international standards, the font size selected must be in proportion to the size of the label. f. Proper steps should be taken, depending upon the nature of the package, to ensure that the label does not get detached/erased/removed from the container/package. g. Nutritional information per 100 gm or 100 ml or per serving of the product shall be given on the label. However, in the case of agricultural raw materials like crops, vegetables, spices, sugar, and non-nutritional products, it would not be mandatory to declare the nutritional value of such products. h. If the field of vision of an individual package is less than 100 sq. cm, it would not be mandatory to declare the list of ingredients used, nutritional facts and directions for use if: (i) It is ensured that such information is already displayed in the wholesale package/wrapper (ii) It is ensured that at the retail level such information is provided to the consumer by way of leaflets etc., as per requirement.

Conditions for labelling of packaged food products (Regulation 9)	If a food or food product is declared as a baby-food or a supplement thereof, the label must indicate the "Best Before Date" in addition to strictly and mandatorily adhering to the provisions of the "Alternative to mother's milk, baby-food, commercially manufactured baby-food supplement, and their usage method (Marketing Control) Laws, 2013".
Nutritional information (Regulation 16)	(1) Labels of packaged food products shall mandatorily contain nutritional information as per the following: - Energy value - Quantity of fat, saturates, salt, sugar, non-vegetarian content used (2) If salt is present in the food product only due to natural reasons, a declaration to that effect shall be made along with the nutritional information.
Dissemination of misleading information (Regulation 18)	1) While fulfilling the provisions of the guidelines provided above, no misleading and false information shall be furnished in the labels which are in contravention of the existing laws and such information shall not be used in advertising the product or in publicizing the same in printed or any other form. 2) Any person found guilty of contravening the provisions of (1) above shall be deemed to have violated sections 41 and 42 of the Food Safety Act 2013.

A3.4 The Consumers' Right Protection Act 2009 (5)

Title	Relevant provision
Definition clause (Section 2)	
Foodstuff	Any article of food including fruits and drinks for the livelihood, nutrition, and protection of health for human, fishes, and livestock;
Consumer	Any person: (a) who, without resale or commercial purpose: (i) buys any goods for a consideration which has been paid or promised to be paid; (ii) buys any goods for a consideration which has been partly paid and partly promised; or (iii) buys any goods for a consideration under any system of deferred payment or installment basis; (b) who uses any good bought under clause (a) with the consent of the buyer; (c) who buys any goods and uses it commercially for the purpose of earning his livelihood by means of self-employment;
Anti-consumer right practice	… to deceive consumers by untrue or false advertisement for the purpose of selling any goods or service; …
Establishment of Council (Chapter II)	The National Consumers' Right Protection Council shall be established for carrying out the purposes of this Act. It shall be a 24 Member Committee with a wide representation. The tenure of any nominated member of the Council shall be two years and six months from the date of his nomination. The Council, inter alia, is responsible for making necessary regulations for the purposes of the Act and to formulate policy on the protection of the rights of the consumers.
Directorate (Section 18)	For carrying out the purposes of this Act, there shall be a Directorate to be called the Directorate of National Consumers' Right Protection. The Directorate shall give assistance to the Council in performing all its functions and shall be responsible for the execution of the decisions of the Council. A Director-General of the Directorate shall be appointed by the Government. A complaint under the Act shall be addressed to the Director-General or any officer of the Directorate empowered in this behalf.

Value Added Tax Act 1991 (6)

The Value Added Tax and Supplementary Duty Act 2012 (7)[1]

	Sugar Sweetened Beverage/ Soft Drinks (Komol Panio)					Energy Drink				
	Import (HS 2202.10.00)			Domestic		Import			Domestic	
Type of tax	Tax base	Duty on import of 'Beverage Concentrate' (%)	Duty on import of finished product (%)	Tax base	Duty on domestically produced product (%)	Tax base	Duty on import of raw material (%)	Duty on import of finished product (%)	Tax base	Duty on domestically produced product (%)
Customs Duty (CD)	CIF	10	25							
Supplementary Duty (SD)	CIF + CD		150		25					35
Value Added Tax (VAT)	CIF + CD + SD + RD	15	15		15					15
Advance Income Tax (AIT)	CIF + CD		5							
Regulatory Duty (RD)	CIF + CD + SD		3							
Advance Trade VAT (ATV)			5							
Total Tax Incidence (TTI)		37.07	293.27							
Revenue earned in FY 2018 – 19					980.74					

* CIF: Cost, Insurance and Freight (CIF) value

[1] This table was provided as part of the desk reviews conducted by WHO under the Global RECAP Programme. WHO Legal and Regulatory Mapping: Bangladesh, 22 April 2020; Sri Lanka, 17 February 2021 (programmatic documents).

A3.6 Physical activity

- **Road Transport Act, 2018 (8)**
  - Identifies the responsibilities of drivers to pedestrians.
  - Protects the right of pedestrians to move safely across the road.
- **Playgrounds, Open Spaces, Parks, and Natural Reservoirs Conservation Law, 2000 (9)**
  - The law applies to the protection of playgrounds, open spaces, parks, and natural reservoirs.
- **Real estate and urban development and management related laws, 2010 (10)**
  - The laws are applicable to the creation of private residential areas that promote a physical activity-friendly urban development by ensuring creation and maintenance of open spaces, playgrounds, and sports facilities in the city.
- **Local Government (City Corporation) Act, 2009 (11)**
  - The City Corporation has the mandate to regulate the movement of vehicles to ensure that pedestrians are not endangered by traffic and can move safely and effortlessly. It also has the authority to build, maintain and manage gardens necessary for public use and recreation.
  - The City Corporation has the authority to take any action to improve public health, including promoting health education.
- **National Youth Policy, 2017 (12)**
  - The policy states that sport should be included in the compulsory curriculum of education, to ensure the well-being of young people.
- **National Integrated Multidimensional Based Transport Policy, 2013 (13)**
  - The policy aims at improving the quality of infrastructure for pedestrians, especially children, women, older people, and those with special physical needs. The policy states that pedestrian priority programmes will be adopted to construct pedestrian-friendly roads by creating wide footpaths, ensuring safe measures for pedestrians to cross the road safely. It also suggests implementing vehicle speed and noise control systems and ensuring the presence of separate lanes for cycling on city roads.
- **National Education Policy, 2010 (14)**
  - The policy includes the recruitment of trained teachers in physical education and the availability of playgrounds among the eligibility criteria for the registration of new educational institutions. It also requires the provision of physical education equipment in schools and budget allocation towards that end.
- **National Land Transport Policy, 2008 (15)**
  - The policy aims to create a more pedestrian-friendly environment by building more footways in urban areas, and by placing emphasis on pedestrian crossing facilities, especially the development of safe crossings. It also aims at better traffic regulation through signal-controlled pedestrian facilities.

References for Annex 3[1]

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13 National Integrated Multidimensional Based Transport Policy. Dhaka: Government of the People's Republic of Bangladesh; 2013 (Inner Makeup Final (Link) .

14 National Education Policy. Dhaka: Government of the People's Republic of Bangladesh; 2010 (https://moedu.gov.bd/site/page/318a22d2-b400-48a7-8222-303ab11cc205/-).

15 National Land Transport Policy. Dhaka: Ministry of Communications; 2008 (Bangladesh National Land Transport Policy - IRF gTKP - global Transport Knowledge Practice).

[1] Much information in Annex 3 builds on the desk review conducted under the Global RECAP Programme. WHO Legal and Regulatory Mapping: Bangladesh, 22 April 2020 (programmatic document). Additional information presented in this Annex, particularly the translations of Bengali legislation and policies, has been provided by the Center for Law and Policy Affairs, Bangladesh, through a policy brief.

ANNEX 4

Sri Lanka Food Marketing, Labelling & Formulation, Consumer Protection, Excise Act and Physical Activity

A4.1 The Food Act 1980 (1)

Title	Relevant provision
Prohibition on manufacture, importation, sale, and distribution of food (Section 2)	No person shall manufacture, import, sell or distribute any food: (a) that has upon it any natural or added deleterious substance which renders it injurious to health; (b) that is unfit for human consumption…
Labelling, packaging, and advertising (Section 3)	1. No person shall label, package, treat, process, sell or advertise any food in a manner that is false, misleading, deceptive, or likely to create an erroneous impression, regarding its character, value, quality, composition, merit, or safety. 2. Any food that is not labelled or packaged as required by the regulations made under this Act or IS labelled or packaged contrary to such regulations shall be deemed to be labelled or packaged contrary to subsection (1).
Prescription of standards (Section 4)	Where a standard is prescribed for any food, no person shall label, package, sell or advertise any food which does not conform to that standard in such a manner as is likely to be mistaken for the food for which the standard has been prescribed.
Administration (Part II)	A 19 Member Food Advisory Committee is formed under the Act, consisting of the following members: - Director of Health Services shall be the Chairman of the Committee; - The Assistant Director of Health Services in charge of Food Control Administration shall be the Secretary of the Committee; - The Government Analyst or any officer nominated by him; - The City Analyst of the Colombo Municipality; - The Principal Collector of Customs or any officer nominated by him; - The Chief Medical Officer of Health of the Colombo Municipality; - One representative from the Ministry charged with the subject of Food; - One representative of the Ministry charged with the subject of Trade; - One representative of the Ministry charged with the subject of Local Government; - One representative of the Bureau of Ceylon Standards; - One nutritionist from the Medical Research Institute; - One food technologist nominated by the Minister; - Two experts in food science nominated by the Minister; - Two members nominated by the Minister to represent the interests of the consumer; and - The Chief Food & Drug Inspector
Authorized officer (Section 13)	The Minister may approve a Medical Officer of Health, Food and Drugs Inspector, Food Inspector, Public Health Inspector as an Authorized Officer of a Food Authority. An authorized officer has the power to enter a premises for examination and assessment.
Enforcement proceedings (Section 18)	Every person who contravenes any of the provisions of this Act or any regulations made thereunder or fails to comply with any direction given under this Act shall be guilty of an offence and shall be liable on conviction.
Regulations (Section 32)	The Minister may make regulations in respect of matters required by this Act to be prescribed or in respect of which regulations are authorized to be made.

Interpretation (Section 33)	
Advertisement	any representation by any means whatsoever for the purpose of promoting directly or indirectly the sale or disposal of any food;
Food	any article manufactured, sold, or represented for use as food or drink for human beings and includes any article which ordinarily enters into or is used in the composition or preparation of food;
Label	a tag, brand, mark, pictorial, or other description, either written, printed, stenciled, marked, embossed, or impressed on or attached to a container of food;
Labelling	a label and any written, printed, or graphic matter relating to or accompanying any food;
Package	anything in which any food is wholly or partly contained, placed, or packed;

A4.2 Food (Labelling and Advertising) Regulations 2022 (2)

Title	Relevant provision
Labelling declarations (Regulation 4)	(2)(a) The following declarations shall be made indelibly and legibly on any panel in any one or more of the three languages- … (i) a complete list of ingredients used in the food by their common names in descending order of ingoing weight (m/m);
Prepackaged food (Regulation 7)	1. Prepackaged food shall not be described or presented on any label by words, pictorial or other devices which refer to or are suggestive either directly or indirectly, of any other product with which such food might be confused, or in such a manner as to mislead the purchaser or consumer to suppose that the food is connected with such other product. 2. No fruit-based beverages for direct consumption or reconstitution shall be described in any label or advertisement as an identical fruit- based beverage, unless it contains an amount of fruit juice of such fruit in accordance with the quantities specified in the Schedule, otherwise it shall be described as "artificial syrup," "artificial cordial" or "artificial beverage" … 4. Any label or advertisement relating to any food product referred to as "artificial" in the regulations shall: (a) bear thereon clearly and conspicuously the word "artificial" in close proximity to the name of the product and the type and size of the letters of such word shall be of the same type and size of the letters used for the common name of the product; (b) not bear the word "fruit" in the description of such product or carry thereon the picture of any fruit;

False claim or misleading description (Regulation 12)	1. No label or advertisement relating to any article of food shall contain a false claim or misleading description of such food in such a manner as to mislead the purchaser or consumer of such food. 2. No food shall be described or presented in a manner that is false, misleading, or deceptive or is likely to create an erroneous impression regarding its character in any respect. 3. For the purpose of this regulation "Claim" means any representation which states, suggests, or implies that a food has qualities relating to its origin, nutritional properties, nature, processing, composition, or any other quality. 4. Any food for which a nutrition claim, a nutrient content claim, a nutrient comparative claim or a health claim is made shall be in accordance with Nutritional Labelling specified in Schedule IV. 5. (a) The nutrient content claims and nutrient comparative claims permitted shall be related to protein, dietary fibre, vitamins, and minerals or which NRVs are specified in Schedule V. If NRV or the nutrient is not specified in Schedule V, prior written approval shall be obtained from the Chief Food Authority. (b) No label or advertisement relating to any food shall contain a nutrient content claim or nutrient comparative claim unless conditions specified in Schedules VI and VII hereto are adhered to. (c) Where applicable, the conditions for nutrient content claims and nutrient comparative claims shall be used to determine the levels or "high," "low", "reduced" and "free" according to Schedules VI and VII hereto. (d) If the fortification level of a nutrient exceeds one third (1/3) of the NRV, prior written approval shall be obtained from the Chief Food Authority, before such products are marketed. 6. (a) Every health claim and Nutrient Function Claim, shall have prior written approval by the Chief Food Authority before a claim can be made on the label or advertisement of the food. ... … (d) Any claim shall not be made if it encourages or condones excessive consumption of any food or disparages good dietary practice ... 12. (a) No label or advertisement relating to any food shall state that dietary fats are a protection against heart diseases or of benefit to persons suffering from heart disease. (b) No label or advertisement relating to any food shall indicate directly or indirectly that such food contains, restorative or medicinal property or properties which make it beneficial or invalids or which will alleviate or prevent any illness unless prior approval has been obtained from the Chief Food Authority. (c) No label or advertisement relating to any food shall indicate directly or indirectly that such food is a cure for any illness. (d) No label or advertisement relating to any food shall claim such food to be an aid for slimming, weight gain, weight control or weight reduction unless prior approval has been obtained from the Chief Food Authority.
Health claims (Regulation 13)	1. A person shall not advertise any advertisement containing any health claim or nutrient function claim relating to any food, without prior written approval of the Chief Food Authority.
Food promotion to children (Regulation 18)	18. A person shall not promote any food directly or indirectly to children under twelve (12) years of age by way of advertisements, leaflets, free samples, articles, or toys attached to food items or separately or by using cartoon character, mascot or celebrities or any other form, unless approved by the Chief Food Authority.

A4.3 Consumer Protection Act 1979 (3)

Title	Relevant provision
Directions for labelling (Section 6)	To protect consumer interests, the Commissioner may issue general directions to manufacturers or traders in respect of labelling, price-marking, and packaging of any article…
Labelling, packaging, and advertising (Section 3)	The Commissioner may enter into such written agreements as he may deem necessary with any manufacturer, trader or association of manufacturers or traders to provide for: … (e) any other conditions as to the manufacture, marketing, labelling or sale of that article.
Misleading or deceptive conduct (Section 18)	No trader shall, in the course of a trade or business, engage in conduct that is misleading or deceptive.
False representation (Section 19)	Any trader who, in the course of a trade or business, in connection with the supply or possible supply of goods or services or in connection with the promotion by any means of supply or use of goods or services: … (c) represents that goods or services have sponsorship, approval, performance, characteristic accessories, uses or benefits they do not have; or … (f) makes false or misleading statements concerning the need for any goods, services, replacements, or repairs; … shall be guilty of an offence under this Act.
Interpretation (Section 37)	
Trader	Any person carrying on business as: (a) an importer of articles for the purposes of sale and supply; (b) an exporter of articles in pursuance of a contract of sale or supply, and includes: (i) a person who sells or supplies articles wholesale to any other traders; (ii) a person who sells or supplies articles at retail rates to consumers.

A4.4 Order Under Article 3 Excise (Special Provisions) Act 1989 (4, 5)

Description	Rate
Waters, including mineral waters and aerated waters, containing added sugar or other sweetening matter, or flavored	Rs. 12 per liters or 50 Cts per gram of sugar contained in the product
Rs. 12 per liters or 50 Cts per gram of sugar contained in the product	Rs. 12 per liters or 50 Cts per gram of sugar contained in the product
Other	Rs. 12 per liters or 50 Cts per gram of sugar contained in the product

Ct: Carat

A4.5 Other Food regulations (6)

In the regulatory capacity under the Food Act as above (A4.1).

Food (Trans-Fat) Regulations 2022

Description	Relevant Provisions
Labelling (Regulation 2)	A person shall not sell, offer for sale, expose, or keep for sale or advertise for sale, any packaged food product containing trans-fat unless the total amount of trans-fat of such food product as per 100g or 100ml of the food product is declared on the label of such packaged food product.
Scope (Regulation 3)	These regulations shall not apply in respect of food products manufactured exclusively for the purpose of export.
Limits on industrially produced trans-fat (Regulation 4)	A person shall not engage in retail sale or wholesale of any food product intended to be used by a final consumer, which the content of trans-fat, other than trans-fat naturally occurring in fat of animal origin, exceeds two percent of the total fat contained in the food.
Consumers' information (Regulation 5)	Any person engaged in the business of supplying as ingredients, food products, to manufacturers of other food products, intended to be used by final consumers, shall provide information to such manufacturer on the amount of trans-fat other than naturally occurring trans-fat of animal origin, where such amount exceeds two percent of the total fat contained in the food.
Ban on partially hydrogenated oils (Regulations 6-7)	A person shall not manufacture, import, transport, distribute, store, sell, offer for sale, expose, or keep for sale, advertise for sale any partially hydrogenated oils. A person shall not use partially hydrogenated oils in the preparation of food or as an ingredient in food products.

Food (Colour Coding for sugar levels – liquid) Regulations 2022

Description	Relevant Provisions
Scope (Regulation 1)	1. Any liquid food which is in a ready to drink form and which contains sugar shall be labeled in the manner as specified in these regulations. … 3. Where any food refers to in this regulation is a pre-packaged imported product, a supplementary label may be affixed on the container or the package of such food and such label shall contain the logos as specified in these regulations.
Labelling (Regulations 3 and 4)	1. Where any food referred to in these regulations contains any amount of sugar specified in Column I of the schedule hereto, the label of such container or the package which contains such food shall have the corresponding logo (hereinafter referred to as "the logo") specified in Column III of the Schedule hereto in the corresponding color specified in Column II of the schedule hereto. 2. The logo specified in sub-regulation (1) of this regulation shall be prepared, designed, and displayed in accordance with the following: (a) the height of the logo shall not be less than 2 cm and the width of the logo shall not be less than 1 cm; (b) (i) a description of the "sugar" content in such food shall be as specified in Column III of the schedule hereto and shall be displayed within the logo in Sinhala, Tamil and English languages respectively in bold white and shall be of minimum 2 mm font size; (ii) a numeric description of the sugar content in such food shall be within a white box as shown in Column III of the schedule hereto and shall be of minimum 1.5 mm font size in bold black. 4. The logo shall be displayed in the main panel of the label of the container or the package which contains such food.

Schedule

(Regulation 3)

Column I Sugar content	Column II Colour	Column III Logo
more than 8.0g/100ml	Red	
2.5g to 8.0g/100ml	Amber	
Less than 2.5g/100ml	Green	

A3.6 Physical activity

National Institute of Occupational Safety and Health Act (2009) (7)

- The relevant stakeholder under this Act is the National Institute of Occupational Safety and Health.
- Section 3 of the Act lists the primary objectives of the Institute, which include: (i) advising the Government on the formulation of a national policy on occupational safety and health; and (ii) advising the government on the working environment while considering the nature of the occupation and the safety of employers and employees.

Town and Country Planning Ordinance (1947) (8)

- The relevant stakeholder under this Ordinance is the National Physical Planning Department.
- Section 4 of the Ordinance sets apart land for the purpose of public parks, natural reserves, and open spaces.

[1] Much information in Annex 4 builds on the desk review conducted under the Global RECAP Programme. WHO Legal and Regulatory Mapping: Sri Lanka, 17 February 2021 (programmatic document).gladesh, through a policy brief.

References for Annex 4[1]

1 Food Act. Colombo: Government of Sri Lanka; 1980 (https://eohfs.health.gov.lk/food/index.php?option=com_content&view=article&id=17&Itemid=158&lang=en).

2 Food (Labelling and Advertising) Regulations. Colombo: Government of Sri Lanka; 2022 (https://eohfs.health.gov.lk/food/images/2319-40_E.pdf).

3 Consumer Protection Act (Chapter 219). Colombo: Government of Sri Lanka; 1979 (cp219289.pdf (commonlii.org)).

4 Excise (Special Provisions) Act. Colombo: Government of Sri Lanka; 1989 (https://www.lawnet.gov.lk/excise-special-provisions-2/).

5 Food (Trans-fat) Regulations Colombo: Government of Sri Lanka; 2022 (https://eohfs.health.gov.lk/food/images/2319-41_E.pdf); Food (Colour Coding for Sugar Levels). Colombo: Government of Sri Lanka; 2022 (https://eohfs.health.gov.lk/food/images/2319-42_E.pdf).

6 National Institute of Occupational Safety and Health Act. Colombo: Government of Sri Lanka; 2009 (PL 003506 N. I. of O. Safety and Health (Act, No. 38 of 2009 Cov).pmd (ilo.org)).

7 Town and Country Planning Ordinance (Chapter 605). Colombo: Government of Sri Lanka; (https://faolex.fao.org/docs/pdf/srl37912.pdf).