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Using the right to health framework to tackle non-communicable diseases in the era of neo-liberalism in Uganda

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Summary: *The main objective of this article is to reflect on how the right to health framework may be used to tackle non-communicable diseases in the era of neo-liberalism in Uganda. NCDs, also known as chronic or lifestyle diseases, cause many deaths. The risk factors for NCDs include the harmful use of alcohol, physical inactivity, salt intake, tobacco use, raised blood pressure, diabetes, obesity, as well as ambient and household air pollution. The article moves beyond the recognition of these important risk factors and interrogates the contribution of neo-liberalism to the prevalence of NCDs. The article argues that neo-liberalism, which emphasises the role of market forces in dealing with socio-economic questions, significantly contributes to the NCDs challenge in Uganda. The article concludes that the right to health can and should play a critical role in tackling the challenge of NCDs in Uganda. Unless policy challenges associated with neo-liberalism are tackled, current NCD prevention, control and management efforts that focus on individual behaviour or lifestyle approaches and place the burden of responsibility on the individual may not achieve the desired results.*

Key words: *non-communicable diseases; neo-liberalism; Uganda; right to health; public health efforts; individualism*

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1 Introduction

The main objective of this article is to reflect on how the right to health framework might be used in the prevention, treatment and control of non-communicable diseases (NCDs) in the era of neo-liberalism in Uganda. As is the case in many countries, Uganda is party to human rights instruments that guarantee the right to health¹ and outline state obligations towards the realisation of the right, including the prevention and treatment of diseases. The Constitution of the Republic of Uganda further contains provisions with a bearing on the right to health.² Several public health policies and interventions are aimed at the promotion of the right.³

Globally, the recognition of health as a human right has gained traction in certain areas, for example, in the field of sexual and reproductive health, including HIV. There is an increased recognition of the role of law, including human rights, in the struggle to tackle NCDs, also known as chronic or lifestyle diseases. The World Health Organization (WHO) recognises human rights as one of the primary approaches in the prevention and control of NCDs.⁴ De Vos et al also advocate a right to health-based approach to the prevention and control of NCDs.⁵ Magnusson and Patterson advocate human rights-inspired legal and governance reforms as part of a comprehensive global response to NCDs.⁶ Ferguson et al argue that human rights can guide governments in strengthening their national laws and policies in response to NCDs.⁷ Gruskin et al observe that the contribution

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- 1 International Covenant on Economic, Social and Cultural Rights (ICESCR) 993 UNTS 3 ratified on 21 January 1987; Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) 1240 UNTS 13 ratified on 22 July 1985; Convention on the Rights of the Child (CRC) 1577 UNTS 3 ratified on 16 September 1990; African Charter on Human and Peoples' Rights (African Charter) ratified on 10 May 1986; Convention on the Rights of Persons with Disabilities (CRPD) ratified on 25 September 2008; and the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (African Women's Protocol) ratified on 22 July 2010.
 - 2 Objectives XX, IV and arts 8A, 39 & 45 of the Constitution.
 - 3 Ministry of Health *The Second National Health Policy* (2010); Ministry of Health Sector Development Plan 2015/16-2019/20 (2015).
 - 4 WHO *Global action plan for the prevention and control of non-communicable diseases 2013-2020* (2013) 12.
 - 5 P de Vos et al 'A human right to health approach for non-communicable diseases' (2013) (381) *The Lancet*, [https://www.thelancet.com/action/show/pdf?pii=S0140-6736\(13\)60274-3](https://www.thelancet.com/action/show/pdf?pii=S0140-6736(13)60274-3) (accessed 25 April 2020).
 - 6 RS Magnusson & D Patterson 'The role of law and governance reform in the global response to non-communicable diseases' (2014), <https://doi.org/10.1186/1744-8603-10-44> (accessed 26 April 2020); RS Magnusson et al 'Legal capacities required for prevention and control of non-communicable diseases' (2019) 97 *Bulletin of World Health Organization* 108-117 doi.10.2471/BLT.18.213777 (accessed 30 April 2020).
 - 7 L Ferguson et al 'Non-communicable diseases and human rights: Global synergies, gaps and opportunities', <http://dx.doi.org/10.1080/17441692.2016.1158847> (accessed 26 April 2020).

of human rights to NCD prevention and control remains nascent and there thus is a need for the infusion of human rights into NCD programme design, monitoring and evaluation.⁸

According to the WHO, NCDs kill 41 million people annually, the equivalent of 71 per cent deaths globally.⁹ Each year 15 million people in low and middle-income countries die from a NCD between the ages of 30 and 39 years.¹⁰ Cardiovascular diseases account for most NCD deaths, or 17,9 million people annually, followed by cancer (9 million), respiratory diseases (3,9 million) and diabetes (1,6 million).¹¹ The 2030 Agenda for Sustainable Development recognises NCDs as a major challenge to sustainable development.¹² Goal 3 of the Agenda aims to 'ensure healthy lives and promote well-being for all' and outlines a number of objectives relevant to the response to NCDs. Target 4 addresses the reduction of premature mortality from NCDs and the promotion of mental health and well-being. Risk factors related to NCDs include the harmful use of alcohol, physical inactivity, salt or sodium intake, tobacco use, raised blood pressure, diabetes, obesity, ambient and household air pollution.¹³ Bad food, nutrition and diet are closely linked to the increase in NCDs,¹⁴ which not only affect adults. Children and adolescents, who are targeted by food and beverage companies through advertisements, may become victims of behaviour such as tobacco use, alcohol abuse and unhealthy diets.¹⁵

In Uganda the incidence and prevalence of NCDs are increasing at an alarming rate.¹⁶ The common types of NCDs in the country, which are precipitated by the above risk factors, include diabetes, cancer, cardiovascular disease such as heart attacks and strokes as well as chronic respiratory diseases.¹⁷ The burden of NCDs is

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- 8 S Gruskin et al 'Non-communicable diseases and human rights: A promising synergy' (2014) 104 *American Journal of Public Health* 773.
- 9 WHO 'Non-communicable diseases: Key facts' (2018), <http://www.who.int/news-room/fact-sheets/detail/noncommunicable-diseases> (accessed 24 October 2018).
- 10 As above.
- 11 As above.
- 12 UN *Transforming our world: The 2030 Agenda for Sustainable Development* (2015).
- 13 As above.
- 14 C Lachat et al 'Diet and physical activity for the prevention of non-communicable diseases in low and middle-income countries: A systematic policy review' (2013) 10 *Public Library of Science and Medicine* 6.
- 15 J Proimos & JD Klein 'Non-communicable diseases in children and adolescents' (2012) 130 *Pediatrics Perspectives* 3.
- 16 Ministry of Health 'Non-communicable diseases', <http://www.health.go.ug/community-health-departments/non-communicablediseases> (accessed 24 October 2018).
- 17 As above.

increasing in both urban and rural areas.¹⁸ According to 2016 estimates, approximately 297 000 people died due to NCDs with cardiovascular disease accounting for 10 per cent of mortality; cancer 10 per cent; chronic respiratory disease 2 per cent; diabetes 2 per cent; and other NCDs 11 per cent.¹⁹ As noted above, in Uganda, alcohol abuse, tobacco use, unhealthy foods and physical inactivity contribute to the burden of NCDs.²⁰

Several commentators have argued that neoliberalism has shaped and influenced NCD policy design and implementation in many countries. Battams argues that the neoliberal paradigm ‘shapes the supply of unhealthy goods’, contributing to the burden of NCDs.²¹ She further argues that trade and development policies largely are influenced by neo-liberalism resulting in trade and economic development goals trumping health goals linked to NCDs. Lenchucha and Thow argue that in low-income countries such as Zambia, neo-liberalism conditions the policy environment in a way that promotes the use of tobacco, alcohol and other unwholesome goods.²² They have further observed that economic sectors, including trade, industry and agriculture, do not pay attention to the health consequences of their policies. Glasgow and Schrecker observe that most commentators view the challenge of NCDs as related primarily to individual choice and behaviour.²³ Yet, neo-liberalism – for example through trade liberalisation and marketing activities of transnational corporations (TNCs) – significantly contributes to the global burden of disease, including NCDs.²⁴

In Uganda public health messages target individual behaviour and prioritise the risk factors of smoking, alcohol abuse and physical inactivity. These messages are in concordance with the neoliberal paradigm, which underlines the values and virtues of the market,

18 C Kiiza Mondo et al ‘The prevalence and distribution of non-communicable diseases and their risk factors in Kasese district, Uganda’ (2013) 24 *Cardiovascular Journal of Africa* 52.

19 WHO ‘Non-communicable Diseases (NCD) Country Profile ‘Uganda’ (2018), http://www.who.int/nmh/countries/uga_en.pdf (accessed 22 October 2018).

20 Ministry of Health (n 16).

21 S Battams ‘Neo-liberalism, policy incoherence and discourse coalitions influencing non-communicable disease strategy: Comment on how neoliberalism is shaping the supply of unhealthy commodities and what this means for NCD prevention’ (2020) 9 *International Journal of Health Policy Management* 116, doi:10.1517/ijhpm.2019.95 (accessed 28 April 2020).

22 R Lenchucha & AM Thow ‘How neoliberalism is shaping the supply of unhealthy commodities and what this means for NCD prevention’ (2019) 8 *International Journal of Health Policy Management* 514.

23 S Glasgow & T Schrecker ‘The double burden of neoliberalism? Non-communicable disease policies and the global policy economy of risk’ (2015) 34 *Health and Place* 279.

24 As above.

individual liberty, choice and freedom.²⁵ As Tarryn and Cella observe, such messages assume that people have the agency to make healthy choices.²⁶ Although messages targeting individual behaviour contribute to a reduction of NCDs in Uganda, there is a need to investigate the contribution of structural and systemic factors such as neo-liberalism, which may constrain the state's capacity to prevent and control NCDs.

Against the backdrop outlined above the article argues that neo-liberalism, which emphasises the role of market forces in dealing with socio-economic questions, significantly contributes to the prevalence of NCDs in Uganda. The article further argues that some of the challenges posed by neo-liberalism are surmountable through a holistic and comprehensive application of the right to health framework. The article is divided into five parts. The first part is this introduction. In the second part I examine the right to health framework at the international, regional and national levels. I tease out the normative scope and content of the right with specific reference to interpretation by the Committee on Economic, Social and Cultural Rights (ESCR Committee).²⁷ The third part of the article examines the contribution of neo-liberalism to the NCD challenge in Uganda. I commence with an examination of neo-liberalism and proceed to illustrate how it adversely impacts on the struggle to tackle NCDs. I argue that neo-liberal policies, such as privatisation and liberalisation, significantly contribute to the NCDs trajectory in the country. The fourth part of the article explores the role that the right to health framework can and should play in tackling the NCD trajectory. In this part I argue that the right to health framework, with its emphasis on both health care and the social determinants of health, can and should play a fundamental role in tackling the risk factors related to NCDs that are exacerbated by neo-liberalism. Part 5 offers concluding remarks.

2 Right to health framework

The WHO, which defines health as a 'state of complete physical, mental and social well-being and not merely the absence of disease and infirmity', recognises the right to health as a fundamental human

25 On the market's sacrosanctity, see M Friedman *Why government is the problem: Essays in public policy* (1993).

26 P Tarryn & M Cella '“We invited the disease to come to us”: Neoliberal public health discourse and local understanding of non-communicable disease causation in Fiji' (2018) 28 *Critical Public Health* 560.

27 ESCR Committee General Comment 14 'The right to the highest attainable standard of health (art 12)', E/C.12/2000/4.

right.²⁸ However, this definition by the WHO has been criticised by several commentators. Evans argues that the definition should not be taken 'at face value'²⁹ and that it is better to think of health in terms of what society can do collectively 'to ensure the conditions in which people can be healthy'.³⁰ Evans also observes that health is concerned with 'the art and the science of preventing disease, promoting health, and extending life through the organised efforts of society'.³¹ Huber et al challenge the WHO's definition of health on grounds that the words 'complete state' are static and suggest the adoption of the Ottawa Charter definition of health which emphasises social and personal resources as well as physical capability.³² The Ottawa Charter defines health as 'a resource for everyday life. Health is a positive concept emphasising social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy lifestyles to well-being'.³³

Building on the definition in the Ottawa Charter, Huber et al suggest a new concept of health in terms of the ability to adapt and to self-manage in the face of social and emotional challenges.³⁴ Jambroes et al observe that by looking at health as 'a complete state', the definition is static, does not take into account the changing patterns of morbidity, and has contributed to the medicalisation of society.³⁵ The challenge with these definitions is that they reproduce the biomedical model of disease that largely emphasises biological and behavioural factors. As Yamin has observed, health is not simply 'a question of divine or genetic fate, of random biological events, or individual behaviour',³⁶ but

a matter of justice – a product of social relations as much as biological or behavioural factors. It is the inequities in these social, and inherently

28 WHO *Constitution of the World Health Organisation* (1946).

29 T Evans 'A human right to health?' (2002) 23 *Third World Quarterly* 197.

30 Evans (n 29) 198. See also Institute of Medicine 'What is public health? An introduction', <https://www.publichealth.columbia.edu/public-health-now/news/what-public-health-introduction> (accessed 22 May 2020).

31 As above. See also D Acheson *Independent inquiry into inequalities in health* (1998) 6.

32 M Huber et al 'Health: How should we define it?' (2011) 343 *BMJ* 235.

33 WHO Ottawa Charter for Health Promotion (1986), <https://www.who.int/healthpromotion/conferences/previous/ottawa/en/> (accessed 22 May 2020).

34 Huber et al (n 32).

35 M Jambroes et al 'Implications of health as "the ability to adapt and self-manage" for public health policy: A quantitative study' (2016) 26 *European Journal of Public Health* 412.

36 AE Yamin 'Will we take suffering seriously? Reflections on what applying a human rights framework to health means and why we should care' (2008) 10 *Health and Human Rights* 45.

power relations for which the state (and sometimes other actors) can and should be held accountable from a human rights perspective.³⁷

Thus, there is a need to move beyond the above definitions, including those by the WHO, and interrogate the underlying social, economic, political and cultural factors that shape the health and well-being of individuals and populations.

The Universal Declaration of Human Rights (Universal Declaration), which 'laid a foundation for the human rights movement',³⁸ guarantees every person 'the right to a standard of living adequate for the health of himself and of his family, including food ... medical care and necessary social services'.³⁹

The International Covenant on Economic, Social and Cultural Rights (ICESCR) guarantees everyone the right to 'the highest attainable standard of physical and mental health'.⁴⁰ The ESCR Committee, which monitors state compliance with ICESCR, has provided an authoritative interpretation of this right⁴¹ and noted that 'good health cannot be ensured by a state'⁴² and that 'genetic factors, individual susceptibility to ill health and the adoption of unhealthy or risky lifestyles may play an important role with respect to an individual's health'.⁴³

The ESCR Committee further interpreted the right to health 'as an inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health',⁴⁴ including access to safe water, food, a clean and healthy environment, relevant education and information and participation of individuals and communities in health interventions.⁴⁵ Indeed, most of the risk factors for NCDs outlined above are attributed to individual life styles, and may be tackled through education and information. However, as the ESCR Committee observed, there are 'formidable structural and other obstacles resulting from international and other factors'⁴⁶ that may inhibit the realisation of the right to health by many state parties, including Uganda. Some of these obstacles might be perpetuated by neo-liberal policies of international financial and trade institutions

37 Yamin (n 36) 46.

38 M Mutua *Human rights: A political and cultural critique* (2002) 3.

39 Art 25(1).

40 Art 12(1).

41 General Comment 14 (n 27).

42 Para 9.

43 As above.

44 Para 14.

45 As above.

46 Para 5.

such as the World Bank, the International Monetary Fund (IMF) and the World Trade Organization (WTO). In this vein, the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health has pointed out that the policies of these institutions compel developing countries to open up their markets for foreign direct investment in the food and beverage sectors, which has resulted in aggressive and pervasive marketing that has increased the consumption of unhealthy foods that have been associated with diet-related NCDs.⁴⁷

According to the ESCR Committee, the right to health contains a number of 'interrelated and essential elements',⁴⁸ namely, the availability, accessibility, acceptability and quality of public health facilities, goods and services.⁴⁹ The facilities, goods and services should be physically and economically accessible to everyone without discrimination. There should also be sufficient information about these facilities, goods and services, which should be respectful of medical ethics, culturally, scientifically and medically appropriate.⁵⁰ ICESCR requires state parties to take steps to ensure the 'creation of conditions which would assure to all medical service and medical attention in the event of sickness'.⁵¹ According to the ESCR Committee this requirement includes 'the provision of equal and timely access to basic preventive, curative, rehabilitative services and health education'.⁵² Thus, in addition to preventive measures, including education, information, communication and screening procedures, which are critical in the struggle against NCDs, the state should ensure that treatment options, including palliative care, for the various NCDs are available, accessible, acceptable and of good quality. Pursuant to its obligation to fulfil human rights, the state should ensure that those who are unable, through their own means, to access treatment for NCDs, are provided with the necessary treatment.⁵³

As in the case of other human rights, the state has three types of obligations: to respect, protect and fulfil the right to health.⁵⁴ Under the obligation to respect human rights, the state should 'refrain from

47 Human Rights Council 'Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health: Unhealthy foods, non-communicable diseases and the right to health' A/HRC/26/31.

48 Para 12.

49 Paras 12(a)-(d).

50 As above.

51 Art 12(2)(d).

52 Para 17.

53 Para 37.

54 Paras 34-37.

interfering directly or indirectly with the enjoyment of the right to health'.⁵⁵ A state party violates the obligation to respect if it fails 'to take into account its legal obligations regarding the right to health when entering into bilateral or multilateral agreements with other states, international organisations and other entities, such as multinational corporations'.⁵⁶ Pursuant to their obligation to protect, states should take measures that prevent non-state or private actors from interfering with the enjoyment of the right to health.⁵⁷ The obligation to protect is violated where the state fails to take all necessary measures to safeguard persons within its jurisdiction from deleterious activities of private persons, including corporations.⁵⁸ An example of an omission is a 'failure to regulate the activities of corporations in order to prevent them from violating the right to health'.⁵⁹ The state may further violate the right to health where it fails to take measures to discourage the production, marketing and consumption of tobacco, narcotics, and other harmful substances such as unhealthy foods,⁶⁰ associated with NCDs.

Under the obligation to fulfil human rights, states should 'adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures towards the full realisation of the right to health'.⁶¹ The state violates the obligation to fulfil human rights where it fails to enact or adopt and implement necessary legal and policy frameworks for the realisation of the right to health. Health policy frameworks should identify appropriate right to health indicators and set benchmarks in relation to each indicator.⁶² Insufficient expenditure or the misallocation of public resources may also result in a violation of the right to health.⁶³

According to the ESCR Committee the state's obligations are to be progressively realised in accordance with available resources.⁶⁴ The ESCR Committee observes that, although ICESCR 'provides for progressive realisation'⁶⁵ and recognises 'constraints due to the limits of available resources',⁶⁶ there are obligations 'which are of immediate effect'.⁶⁷ These obligations are 'the guarantee that the

55 Para 33.

56 Para 50.

57 As above.

58 Para 51.

59 As above.

60 As above.

61 As above.

62 Paras 57 & 58.

63 Para 52.

64 Art 2(1).

65 Para 30.

66 As above.

67 As above.

right will be exercised without discrimination of any kind';⁶⁸ and 'the obligation to take steps ... towards full realisation'⁶⁹ of the right. The steps taken by the state 'must be deliberate, concrete and targeted towards full realisation of the right to health'.⁷⁰ According to the ESCR Committee, the concept of progressive realisation 'should not be interpreted as depriving states parties' obligations of all meaningful content'.⁷¹ Thus, state parties 'have a specific and continuing obligation to move as expeditiously and effectively as possible'⁷² in order to ensure the full realisation of the right to health. Retrogressive measures are not permissible unless the state justifies that it took the decision 'after the most careful consideration of all alternatives'.⁷³

The ESCR Committee has affirmed that '[s]tates parties have a core obligation to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights'⁷⁴ in ICESCR. These core obligations include ensuring access to health facilities, goods and services for vulnerable and marginalised groups;⁷⁵ 'access to the minimum essential food which is nutritionally adequate and safe, to ensure freedom from hunger to everyone'; and access to an adequate supply of safe and potable water.⁷⁶ Indeed, there is a link between nutrition and NCDs, and effective public health nutrition is required in order to curb the prevalence of the diseases.⁷⁷ These core obligations also include the provision of essential drugs.⁷⁸ The ESCR Committee lists what it calls 'obligations of comparable priority', which include taking 'measures to prevent, treat and control epidemic and endemic diseases'.⁷⁹

Although other treaties address human rights of everyone, the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) specifically addresses women's human rights in the context of equality and non-discrimination.⁸⁰ State parties are enjoined to 'take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a

68 As above.

69 As above.

70 As above.

71 Para 31.

72 As above.

73 Para 32.

74 Para 43.

75 Para 43(b).

76 Para 43(c).

77 JM Edward Joy et al 'Dietary patterns and non-communicable disease risk in Indian adults: Secondary analysis of Indian migration study data' (2017) 20 *Public Health Nutrition* 1963.

78 Para 43(d).

79 Para 44(c).

80 Art 1 CEDAW.

basis of equality of men and women, access to health services'.⁸¹ State parties are called upon to pay special attention to rural women and ensure that among other things they have access to adequate health care,⁸² including, for example, facilities for testing diabetes, blood pressure, and screening for breast and cervical cancer.

The Convention on the Rights of the Child (CRC) guarantees every child the 'enjoyment of the highest attainable standard of health and for the facilities for the treatment of illness and rehabilitation of health'.⁸³ State parties are called upon to take appropriate measures to ensure children access to both preventive and curative health services.⁸⁴

The Convention on the Rights of Persons with Disabilities (CRPD) guarantees persons with disabilities 'the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability'.⁸⁵ State parties are enjoined to 'take all appropriate measures to ensure access for persons with disabilities to health services that are gender sensitive, including health related rehabilitation'.⁸⁶

At the regional level, the African Charter on Human and Peoples' Rights (African Charter) guarantees everyone 'the right to enjoy the best attainable state of physical and mental health'.⁸⁷ State parties are obliged to 'take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick'.⁸⁸ The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (African Women's Protocol) obliges state parties to 'ensure that the right to health of women, including sexual and reproductive health, is respected and promoted'.⁸⁹ The treaty enjoins state parties to take appropriate measures to 'provide adequate, affordable and accessible health services, including information, education and communication programmes to women especially those in rural areas'.⁹⁰ It also guarantees women the 'right to live in a healthy and sustainable environment'.⁹¹ The African Women's Protocol further

81 Art 12(1).

82 Art 14.

83 Art 24(1).

84 Arts 14(2)(a)-(f).

85 Art 25 CRPD.

86 Arts 25(a)-(b).

87 Art 16(1).

88 Art 16(2).

89 Art 14(1).

90 Art 14(2)(a).

91 Art 18(1).

calls upon state parties to 'ensure greater participation of women in the planning, management and preservation of the environment and the sustainable use of natural resources at all levels'.⁹² It enjoins state parties to 'protect and enable the development of women's indigenous systems'.⁹³ State parties are also called upon to 'provide women with access to clean drinking water, sources of domestic fuel, land, and the means of producing food',⁹⁴ and to 'establish adequate systems of supply and storage to ensure food security'.⁹⁵

The African Charter on the Rights and Welfare of the Child (African Children's Charter) guarantees every child 'the right to enjoy the best attainable state of physical, mental and spiritual health'.⁹⁶ State parties are enjoined to take measures 'to ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care';⁹⁷ to 'ensure provision of adequate nutrition and safe drinking water';⁹⁸ and 'to combat disease and malnutrition'⁹⁹ among children.

The Bill of Rights in the Ugandan Constitution does not expressly provide for the right to health. However, it calls upon the state to promote the social well-being of its people and in particular to ensure that all Ugandans enjoy rights and opportunities and access, among others things, to education, health services, clean and safe water, and food security.¹⁰⁰ The state should take all practical measures 'to ensure the provision of medical services to the population'.¹⁰¹ The Constitution enjoins the state to take appropriate measures to encourage people to grow and store adequate food; to establish adequate food reserves; and to 'promote proper nutrition through mass education and other appropriate means in order to build a healthy state'.¹⁰² In addition to the right to a clean and healthy environment,¹⁰³ the Constitution obliges the state to take all possible measures to 'prevent or minimise damage and destruction resulting from pollution'.¹⁰⁴ The Constitution includes an inclusive provision that renders justiciable other rights, such as the right to health, which

92 Art 18(2)(a).

93 Art 18(2) (c).

94 Art 15(a).

95 Art 15(b).

96 Art 14(1).

97 Art 14(2)(b).

98 Art 14(2)(c).

99 Art 14(2)(d).

100 Objective XIV.

101 Objective XX.

102 Objectives XXII(a)-(c).

103 Art 39.

104 Objective XXVII(ii).

are not expressly provided for in the Bill of Rights.¹⁰⁵ In the next part I interrogate the contribution of neo-liberalism to the challenge of NCDs in the country.

3 Deciphering the contribution of neo-liberalism to non-communicable diseases

3.1 Understanding neo-liberalism

The political context, which includes neo-liberal policies, has an enormous influence on the health of the population and on poverty and inequality.¹⁰⁶ Neo-liberalism, which has significantly contributed to creating and deepening poverty and inequalities,¹⁰⁷ may be traced to the regimes of Jimmy Carter and Ronald Reagan in the United States of America (USA) at the end of the 1970s and 1980s and Margaret Thatcher of the United Kingdom (UK) in the early 1980s.¹⁰⁸ The neo-liberal paradigm advocates a reduction in the role of the state in all economic and social spheres in order to unlock the potential of market forces. It calls for the elimination of all barriers that hinder the expansion of capitalism. Neo-liberalism is manifested in the policies of international financial institutions – the World Bank and the IMF – and the WTO, the leading global trade institution. These institutions believe that neoliberal policies promote economic conditions that will spur economic development, and integrate the local and global economies.¹⁰⁹

In Uganda, as in most African countries, the World Bank and the IMF imposed structural adjustment programmes (SAPs) that emphasise liberalisation, deregulation, privatisation and the compression of state budgets, foreign direct investment, and an increased role of international aid, allegedly to lift populations out of poverty.¹¹⁰ According to these financial institutions, SAPs would

105 Art 45.

106 On the influence of politics on policy outcome, see eg V Navarro 'The importance of politics in policy' (2011) 35 *Australia and New Zealand Journal of Public Health* 313.

107 V Navarro 'Neoliberalism and its consequences: The world health situation since Almata', <http://www.vnavarro.org/wp-content/uploads/2008/07/neo-liberalism-and-its-consequences.pdf> (accessed 28 April 2020); V Navarro 'Neoliberalism as a class ideology; or the political causes of inequalities' (2007) 37 *International Journal of Health Services* 47.

108 D Harvey *A brief history of neoliberalism* (2005).

109 D Karjaner 'World Bank, the International Monetary Fund, and neoliberalism' (2015), DOI:10.1002/9781118663202.wberen414 (accessed 25 April 2020).

110 D Harvey 'Neoliberalism as creative destruction' (2007) 610 *American Academy of Political and Social Science* 21, DOI:10.1177/0002716206296780 (accessed 25 October 2020).

open and liberalise trade whereby all forms of barriers are minimised or removed. African governments, including that of Uganda, were required to adopt an export-led growth strategy that would ostensibly put the countries on the road to recovery. Privatisation was touted as the main driver of growth.¹¹¹ The World Bank and the IMF imposed on these countries market-driven policies such as the privatisation of public enterprises, including water and power utilities and other socio-economic services,¹¹² which are critical for the realisation of the right to health. Privatisation, which included the retrenchment of civil servants, led to massive job losses and higher prices of goods and services that were unaffordable for the majority of citizens. Since the imposition of SAPs, Uganda has implemented neo-liberal policies that are market-oriented and export-led and characterised by the commercialisation or privatisation of public sector functions,¹¹³ including health, water and agriculture. SAPs, which are based on the neo-liberal model of economic growth and development, have produced adverse consequences for health. They have largely been blamed for sacrificing public health and health care, especially for the rural and urban poor.¹¹⁴

3.2 Neo-liberalism, health and non-communicable diseases

If well implemented, neo-liberal policies may lead to economic growth. However, what are the implications of neo-liberalism for health? Neo-liberal policies, which stress a reliance on the market, may lead to the increased commodification of basic social services such as health care, food, water and energy, thereby making them unaffordable for the majority of the population.¹¹⁵ Neo-liberal policies adversely affect health and quality of life. Neo-liberalism, which focuses on markets for health care, ignores the fact that health moves beyond health care and encompasses social determinants of health. An emphasis on the dominance of the neo-liberal market reinforces the trend toward restricting socio-economic rights, including health. Neo-liberalism, with its emphasis on the role of the market in solving

111 For an excellent discussion of the imposition of World Bank and IMF trade and financial liberalisation policies on African countries such as Uganda, see DM Demebele 'The International Monetary Fund and World Bank in Africa: A disastrous record' (2004), <https://www.pambazuka.org/governance/international-monetary-fund-and-world-bank-africa-disastrous-record> (accessed 11 February 2020) (accessed 25 April 2020).

112 On the impact of neo-liberal policies such as privatisation, see AE Birn et al *Textbook of international health* (2009).

113 See AE Birn et al (n 112) 168.

114 AM Mukweya 'Structural adjustment and health' (1995) 311 *British Medical Journal* 71.

115 On how neoliberal policies have adversely affected socio-economic sectors including health and education, see G Martiniello (ed) *Uganda: The dynamics of neoliberal transformation* (2018).

socio-economic questions, erodes the role of the state as a guarantor of these rights and converts rights into individual responsibilities and has a deleterious impact on health. As Brezis and Wiist observe:¹¹⁶

The free market can harm health and health care. The corporate obligation to increase profits and ensure a return to shareholders affects public health. Such excesses of capitalism pose formidable challenges to social justice and public health. The recognition of the health risks entailed by corporation-controlled markets has important implications for public policy. Reforms are required to limit the power of corporations.

One of the tenets of neo-liberalism is that people should be responsible for most aspects of their health with minimal or no state intervention.¹¹⁷ Health is viewed as an individual good to be accessed through individual or family and private health providers. As Chapman observes:¹¹⁸

The neoliberal paradigm views health systems and services as commodities, that is, inputs to productivity and economic growth and sources of potential revenue, rather than as public and social goods. Neoliberal ideology also advocates for a minimal government with most social services provided by the private sector.

Although Uganda over the years has had an impressive economic growth, averaging 6 per cent, which may be attributed to neo-liberal policies implemented by the state, these policies have significantly contributed to an increase in economic and health inequalities.¹¹⁹ A study by Oxfam found that the over-liberalisation of the economy is one of the key drivers of income inequality in the country.¹²⁰ Economic growth has largely been non-inclusive and, as a result, income inequality has significantly increased since the 1990s. According to Oxfam, trends in inequality indicate that

[t]he rich have grown richer while the poor have become poorer, despite overall economic growth. The richest 10 per cent of Uganda's population enjoy over one-third (35,7 per cent) of national income, and this proportion has grown by nearly 20 per cent over the past two decades. The richest 20 per cent claim just over half of all national

116 M Brezis & WH Wiist 'Vulnerability of health to market forces' (2011) 49 *Medical Care* 232.

117 AM Viens 'Neo-liberalism, austerity and the political determinants of health' (2019) 27 *Health Care Analysis* 147.

118 AR Chapman 'Globalisation, human rights, and the social determinants of health' (2009) 23 *Bioethics* 97.

119 J Wiegate 'Fake capitalism? The dynamics of neoliberal restructuring and pseudo-development: The case of Uganda' (2010) 37 *Review of African Political Economy* 123.

120 Oxfam *Who is growing? Ending inequality in Uganda* (2017) 33.

income, this proportion having increased by almost 14 per cent over this period.¹²¹

Income inequality is manifested in poor people's inability to access socio-economic services, including health care. Some people with NCDs suffer in silence because they may not be able to afford the high cost of care. The responsibility for NCDs, especially their treatment and management, is left in the hands of individuals with little intervention by the state. Public health systems, which are accessible by the poor, are on the verge of collapse.¹²² Private health care is accessible only by particular individuals and groups who may afford the high cost of care.¹²³

Neo-liberal policies, especially privatisation and liberalisation, have promoted investment in the private health sector.¹²⁴ However, private healthcare facilities largely promote curative care, with little attention being paid to primary health care, health promotion and disease prevention. The policies also promote limited individual and community participation in design and implementation, which would have revealed the actual socio-economic challenges faced by the people in accessing health care. I have argued elsewhere that neo-liberal policies, which are devoid of grassroots participation, are antithetical to the realisation of socio-economic rights of the poor, including the right to health.¹²⁵ Focusing on medical care, in my view, without tackling the structural causes of ill-health, including the socio-economic determinants of health, may in the long run be counterproductive. The government may deliver the best medical care for the treatment of diseases, including NCDs, but if it does not tackle the underlying causes of the population's poor health status, including miserable living conditions, all interventions will be in vain. The government must tackle the social determinants of health, which in effect are the conditions in which people live and work, which affect their opportunities to lead healthy lives. As Mooney correctly observes, health care must be viewed as a social institution where key social determinants of health, such as primary health care, education, food security and public sanitation, are promoted in a holistic and integrated fashion.¹²⁶ However, health, including

121 Oxfam (n 120) 33.

122 O Kobusingye *The patient: Sacrifice, genius, and greed in Uganda's health care system* (2020).

123 As above.

124 See eg USAID *Uganda's private health sector: Opportunities for growth* (2015).

125 See eg BK Twinomugisha 'A critique of Uganda's Poverty Eradication Plan' in K Matlosa et al (eds) *The state, democracy and poverty eradication in Africa* (2008) 298.

126 G Mooney 'Neo-liberalism is bad for our health' (2012) 42 *International Journal of Health Services* 348.

health care, goes beyond bio-medical factors and encompasses social conditions in which people live and operate. Health comprises more than health-related goods and services and covers critical questions such as non-discrimination, democracy, transparency and accountability. As Yamin observes:¹²⁷

In a rights framework, health is reproduced, experienced and understood in the social, political, historical, and economic contexts in which we live. This perspective forces us to see suffering that is not the result of 'natural' biological causes but rather stems from human choices about policies, priorities, and cultural norms, about how we treat each other and what we owe each other.

The WHO has identified risk factors for NCDs which are the harmful use of alcohol, physical inactivity, salt or sodium intake, tobacco use, raised blood pressure, diabetes, obesity and air pollution.¹²⁸ What is the contribution of neo-liberalism to these factors? What is the role of the free trade or liberalisation of markets and foreign direct investment? Under the neo-liberalism banner, developed countries have used international trade regimes and the trade liberalisation strategy to encourage the export of unwholesome products to developing countries. Kuo Lin et al observe that although an increase in trade may lead to economic growth, increased trade flows in processed food are associated with a rise in the prevalence of NCDs and chronic illnesses.¹²⁹ Garcia-Dorado et al also found a link between trade liberalisation, nutrition outcomes and NCDs.¹³⁰

Relying on the WTO's philosophy of free trade, developed countries have encouraged tobacco exports by transnational conglomerates, which fuel the consumption of tobacco in developing countries such as Uganda.¹³¹ Workman reports that in 2018 global tobacco exports totalled to US \$21,2 billion, with Europe accounting for US \$12,6 billion or 59,4 per cent of the revenue from exported cigarettes.¹³² Although some African countries such as Malawi, Zimbabwe and Uganda grow tobacco, exports from Africa accounted for only

127 Yamin (n 36) 47.

128 WHO 'Non-communicable diseases', <https://www.who.int/news-room/fact-sheets/detail/noncommunicable> (accessed 11 February 2020). On how some of these risk factors play out in Uganda, see O Namusisi et al 'Risk factors for non-communicable diseases in rural Uganda: A pilot surveillance project among diabetes patients at a referral hospital clinic' (2011) 10 *Pan African Medical Journal* 47.

129 T Kuo Lin 'The effect of sugar and processed food imports on the prevalence of overweight and obesity in 172 countries' (2018) 14 *Global Health* 35.

130 SC Garcia-Dorado et al 'Economic globalisation, nutrition and health: A review of quantitative evidence' (2019) 15 *Global Health* 15.

131 ER Shaffer, JE Brenner & TP Houston 'International trade agreements: A threat to tobacco control policy' (2005) 14 *Tobacco Control* 19.

132 D Workman 'Tobacco cigarettes exports by country', www.worldstopexports.com/tobacco-cigarettes-exports-country/ (accessed 30 April 2020).

1,6 per cent.¹³³ It is even possible that some cigarettes and other tobacco products exported to developing and least developed countries may be of poor quality. For example, Deutsch reports that cigarettes sold in Africa are more toxic than those smoked in Switzerland.¹³⁴ International trade law thus has opened up developing country markets to tobacco exports from developed country markets. Cigarette smoking is promoted as part of the 'sophisticated' and 'cute' Western culture. Although the government has attempted to domesticate the WHO Framework Convention on Tobacco Control by enacting the Tobacco Control Act, 2015, the legislation has not been actively implemented.

Neo-liberalism, especially the liberalisation of trade in food, has contributed to a proliferation of fast food restaurants and outlets such as Kentucky Fried Chicken, Café Javas, Chicken Tonight and Java House, which serve potato chips, sausages, kebabs, chaps, fried eggs, chicken and all sorts of oil-filled food. Some of these foods, which are predominantly consumed in urban areas, have been linked to the emergence of NCDs.¹³⁵ These outlets also sell sugar and calorie-loaded chocolate and soft drinks of all types. In my view, the promotion of so-called 'zero sugar' sweetened soft or alcoholic drinks by food and beverage companies not only is deceptive, but a farce aimed at convincing consumers to purchase their products. Yet, the marketing of processed products contributes to negative changes in the dietary habits of the people.¹³⁶ Food and beverage industries promote consumerism through mass media and commercial marketing. In my view, these industries are largely interested in the maximisation of profits to meet the expectations of their shareholders and not necessarily the promotion of the population's health. The consumption of these foods may lead to obesity in children and young people, who are largely targeted by these companies through advertisements. Type 1 diabetes, which has been linked to fast food consumed by children, is on the increase in the country.¹³⁷

There is no doubt that nutrition is an important ingredient of good health. Good nutrition directly contributes to improved health and well-being.¹³⁸ However, neo-liberal agricultural policies, such as the Plan for Modernisation of Agriculture, which promotes the

133 As above.

134 F Deutsch 'The blazing success of Swiss cigarettes in Africa', <http://www.stories.publiceye.ch/tobacco/> (accessed 29 April 2020).

135 WHO *Globalization, diets and non-communicable diseases* (2002).

136 WHO *Fiscal policies for diet and prevention of non-communicable diseases* (2015).

137 Ministry of Health *Non-communicable Disease Risk Factor Baseline Survey Uganda* (2014) 15.

138 See eg FAO 'Pulses and the link between nutrition and health' (2016), www.fao.org/pulses-2016/news/news-detail/en/c/386990/ (accessed 29 April 2020).

commercialisation of agriculture and not self-sufficiency in food, significantly contribute to persistent malnutrition and hunger in the country.¹³⁹ These policies promote land-grabbing, which has resulted in thousands, if not millions, of people driven off their lands.¹⁴⁰ The policies also promote the use of technology in agriculture, which largely favours large-scale farmers to the detriment of small-scale farmers who are displaced from their lands.¹⁴¹ In most developing countries, including Uganda, there is an increased use of pesticides, herbicides and chemical fertilisers in commercial and small scale agriculture, allegedly to increase agricultural productivity.¹⁴² However, the use of these pesticides and fertilisers, especially when not used properly, may have deleterious consequences for the environment and human health.¹⁴³ The majority of farmers who spray the crops, whether on individual holdings or in commercial farms, do not use safety masks, gloves and other protective gear, thereby enabling access of the pesticides in the blood stream. According to Kumari et al, 'chemical fertilizers and pesticides used over a long period of time have adverse toxic effects on the production potential of the land and the ultimate consumers of the agricultural products'.¹⁴⁴ For example, in Vietnam researchers found that pesticide use in agriculture was linked to NCDs.¹⁴⁵ Researchers found that there was illegal business in pesticides with false labels, as well as the marketing of expired or poor quality products in stores, which had adverse health consequences for the population.¹⁴⁶

Uganda has enough land to provide everyone with an adequate diet but, in my view, the main challenge is the unequal distribution and use of land. Instead of encouraging the population to grow organic healthy foods on the available land, the government has overly promoted the growing of cash crops such as sugar cane, coffee, tea and cotton at the expense of food production, ignoring

139 BK Twinomugisha 'Challenges for realisation of the right to food in Uganda' (2005) *East African Journal of Peace and Human Rights* 2.

140 See NAPE *A study on land grabbing cases in Uganda* (2012).

141 Twinomugisha (n 139) 14.

142 See JS Okonya 'A cross-sectional study of pesticide use and knowledge of smallholder potato farmers in Uganda' (2015) *BioMed Research International*, <https://doi.org/10.1155/2015/759049> (accessed 2 May 2020); H Kizito 'Uganda farm families risk death by "eating" pesticides' (2013), <https://news.trust.org/item/20130220030400-mlzst> (accessed 1 May 2020).

143 N Sgarma & R Singhvi 'Effects of chemical fertilisers and pesticides on human health and environment: A review' (2017) 10 *International Journal of Agriculture, Environment and Biotechnology* 675.

144 KA Kumari et al 'Adverse effects of chemical fertilisers and pesticides on human health and environment' (2014) 3 *Journal of Chemical and Pharmaceutical Sciences* 150.

145 HV Dang et al 'Risk factors for non-communicable diseases in Vietnam: A focus on pesticides' (2017) *Frontiers in Environmental Science*, <https://doi.org/10.3389/fenvs.2017.00058> (accessed 10 January 2019).

146 As above.

the fact that people cannot eat these crops. Overly concentrating on cash crops for export rather than those that feed the country's population may be counter-productive. Indigenous food crops in Uganda, such as millet, are becoming extinct in some areas of the country, because of the drive to produce cash crops. Genetically-modified seeds, which are manufactured by Mosanto, and are promoted in developing countries to the detriment of indigenous seeds, may not be affordable to the poor.¹⁴⁷

The National Forest Authority (NFA) has also promoted the establishment of tree plantations such as eucalyptus and pine, which are owned by the rich and wealthy, including foreign investors, whose major interest may not be environmental conservation as such but profit maximisation from the sale of timber. These foreign tree species have a deleterious impact on the environment. For example, eucalyptus has been found to induce soil degradation and adversely affect biodiversity, sustainable cropping, and water conservation.¹⁴⁸ This tree species has replaced native forests and lands where communities have been growing organic foods, which have been found to be more nutritious, healthier and safer than their conventional counterparts, which have less antioxidants and more frequent pesticide residues.¹⁴⁹ Organic foods, including fruits, vegetables and grains, are more beneficial to the environment, as well as humans and animals that inhabit it.¹⁵⁰ In the next part of the article I explore the extent to which the right to health framework may be employed in efforts to tackle NCDs in the country.

4 Tackling the non-communicable disease trajectory: What role can and should the right to health framework play?

The right to health framework is so broad that this article does not claim to engage all its components in the discourse of NCDs in the era of neo-liberalism. However, I believe that a combination of key aspects of the right, namely, the use of juridical measures, community participation, and the gender perspective, might go a long way in

147 See RESET 'The privatisation of seeds', <http://en.reset.org/knowledge/privatisation-seeds> (accessed 28 April 2020).

148 W Jun Zhang 'Did eucalyptus contribute to environmental degradation? Implications from a dispute on causes of severe drought in Yunnan and Guizhou, China' (2012) 1 *Environmental Skeptics and Critics* 34.

149 A Mie et al 'Human health implications of organic food and organic agriculture: A comprehensive review' (2017) (111) *Environmental Health* 16.

150 C Micheal 'Organic fruits and vegetables: Potential health benefits and risks', <https://escholarship.org/uc/item/0c6386bt> (accessed 10 January 2019).

alleviating the NCD burden, provided that there is a strong political will on the part of government actors.

4.1 Juridical measures

4.1.1 Legislative measures

Law plays a critical role in the promotion of public health.¹⁵¹ Magnusson et al have correctly observed that law and regulation, including fiscal measures, are at the centre of national and local NCD action plans.¹⁵² At the United Nations General Assembly (UNGA), Heads of State and Government also committed themselves to '[p]romote and implement policy, legislative and regulatory measures, including fiscal measures as appropriate, aiming at minimizing the impact of the main risk factors from non-communicable diseases, and promote healthy diets and lifestyles'.¹⁵³

The obligation to fulfil the right to health further enjoins the state to take steps, including legislative measures, to prevent, treat and control epidemics such as NCDs. The obligation to protect the right to health also requires the state to take appropriate measures, including legislation, to ensure that activities of private actors, including corporations, do not compromise the enjoyment of the right.

Parliament has the overall responsibility of making laws in the country.¹⁵⁴ In order to 'promote the health of persons and reduce tobacco-related illnesses and deaths',¹⁵⁵ and 'to protect persons from the socio-economic effects of tobacco production and consumption',¹⁵⁶ Parliament enacted the Tobacco Control Act, 2015 which, among others, stresses the right to a tobacco-free environment¹⁵⁷ and imposes a comprehensive ban on tobacco

151 LO Gostin *A theory and definition of public health law* (2008); BK Twinomugisha *Fundamentals of health law in Uganda* (2015).

152 RS Magnusson et al 'Legal capacities required for prevention and control of non-communicable diseases' (2019) 97 *Bull World Health Organ* 108, doi:10.2471/BLT.18.213777 (accessed 30 April 2020).

153 Para 21, UNGA Political declaration of the third high-level meeting of the General Assembly on the prevention and control of NCDs. 'Time to deliver: Accelerating our response to address non-communicable diseases for the health and well-being of present and future generations' A/RES/73/2, 17 October 2018 https://www.un.org/en/ga/search/view_doc.asp?symbol=A/RES/73/2 (accessed 30 April 2020).

154 Art 79(1) of the Constitution.

155 Long title to the Tobacco Control Act, 2015.

156 As above.

157 Sec 11.

advertisement, promotion and sponsorship.¹⁵⁸ The government has a duty to enforce this law and ‘protect the public against the influence of and interference by commercial and other vested interests of the tobacco industry’.¹⁵⁹ Although this legislation, which seeks to fulfil Uganda’s obligations as a party to the WHO Framework Convention on Tobacco Control, is progressive, there is limited enforcement of the law. There is an urgent need for government to mobilise resources for the enhanced enforcement of the law to ensure compliance.

As Magnusson et al recommend,¹⁶⁰ government should build legal capacity to draft and implement appropriate laws and litigate where necessary against corporations that may be fuelling the spread of NCDs. Government may seek support from the WHO to develop laws and regulations on health matters and NCDs, in the form of technical assistance, training and the provision of technical resources. WHO can also support government by providing *amicus* briefs in disputes over tobacco control laws.¹⁶¹ Local governments should also, pursuant to the Local Governments Act,¹⁶² enact bye-laws targeting tobacco smoking in public places. The National Management Authority (NEMA) should also actively enforce the National Environment (Control of Public Smoking in Public Places) Regulations, 2004 and the National Environment Act, 2019, so that Ugandans may enjoy their right to a clean and healthy environment.¹⁶³

Another area requiring regulation is alcohol production and consumption. Studies have found that alcohol abuse is increasing in both rural and urban areas. According to Ndugwa et al,¹⁶⁴ the level of alcohol use among adults in Uganda is high and almost 10 per cent of the adult population has an alcohol abuse-related disorder.¹⁶⁵ Uganda has one of the highest levels of alcohol consumption in the East African region with an annual per capita alcohol consumption of 9,5 litres.¹⁶⁶ Alcohol abuse has been linked to NCDs and accidents. Most of the laws on alcohol use, such as the Enguli (Manufacture and Licensing) Act,¹⁶⁷ and the Liquor Act,¹⁶⁸ were enacted in the early

158 Sec 14.

159 Sec 19(a).

160 Magnusson et al (n 152).

161 As above.

162 Cap 243.

163 Art 39 of the Constitution.

164 N Kabwama et al ‘Alcohol use among adults in Uganda: Findings from the countrywide non-communicable diseases risk factors cross-sectional survey’ (2016) *Global Health Action* 9; see also WHO *Global Status Report on Alcohol and Health* (2014).

165 As above.

166 As above.

167 Cap 86.

168 Cap 93.

and mid-1960s, are outdated and outmoded and need to be revised or repealed. There is a need for alcohol control legislation that explicitly states government's public health objectives for passing the legislation. The legislation should aim at regulating affordability, hours and days of trading in alcohol, alcohol marketing, setting a minimum purchase age of alcohol, and taxation measures, drawing lessons from other jurisdictions.¹⁶⁹ In this vein, Betty Namboozie who introduced a private member's Bill – the Alcohol Control Bill 2016 – should be applauded and supported. Government should also actively enforce the 2017 ban on the production of alcohol in sachets.

The food and soft drinks industries also need to be regulated. The Food and Drugs Act¹⁷⁰ is outdated and outmoded. Legislation that promotes self-sufficiency in food, the establishment of national food reserves, and proper public health nutrition is urgently required. Local governments should also develop bye-laws on effective agricultural practices, food production, storage and processing, such as occurred in the 1960s. The Food and Nutrition Bill 2009 should be urgently resuscitated and discussed in Parliament in order to address the right to food, in a holistic fashion, taking into account NCD food-related challenges. The Bill recognises the right to food as a fundamental human right and aims, among others, at providing a legal basis for implementing the Food and Nutrition Policy.¹⁷¹ The Bill creates an obligation on the government to ensure that food is available, accessible and of good quality especially for vulnerable groups, such as children, pregnant women and the elderly.¹⁷² It also enjoins the government to ensure participation of the people in the design and implementation of food-related policies.¹⁷³ Government is also enjoined to ensure the provision and maintenance of sustainable food systems.¹⁷⁴

Unregulated food advertising may also contribute to the challenge posed by NCDs. Various commentators have advocated the regulation of food advertising, especially because of its link to obesity in children.¹⁷⁵ Montana et al found that over 40 per cent

169 Liquor Act, Queensland, Australia, 1992; Alcohol Act, Norway, 1989; Alcohol Beverage Control Act, Thailand, 2008; WHO *Addressing the harmful effects of alcohol: A guide to developing effective alcohol legislation* (2011).

170 Cap 278.

171 Sec 3.

172 Sec 5.

173 As above.

174 As above.

175 See eg S Graff et al 'Government can regulate food advertising to children because cognitive research shows that its inherently misleading' (2012) *Health Affairs*, <http://doi.org/10.1377/hltaff.2011.0609> (accessed 29 April 2020); JL Harris & SK Graff 'Protecting young people from junk food advertising:

of children in Spain were either obese or overweight due to the low nutritional value of their food.¹⁷⁶ The authors call for stricter legislation targeting nutritional value food advertisements.¹⁷⁷ Indeed, some countries have developed laws aimed at regulating food advertisement. For example, in India regulations made under the Food Safety and Standards Act, 2006 regulate food business advertisements. Under the Food Safety and Standards (Advertising and Claims) Regulations, 2008, which came into force on 1 July 2019, every food business operator and marketeer is prohibited from using words such as natural, fresh, original, finest, best, authentic, genuine and real.¹⁷⁸ The regulations prohibit companies from encouraging or condoning the excessive consumption of a particular food. In South Africa, regulations made pursuant to the Foodstuffs, Cosmetics and Disinfectants Act provide maximum limits for food, including bread, breakfast cereal and porridge, processed meat, savoury snacks and potato chips.¹⁷⁹

In 2016 Chile implemented a law which was directed at children below the age of 14 years.¹⁸⁰ The law required front-package labels, restricted advertising directed at children, and banned the sale in schools of all foods and beverages containing added sugars, sodium or saturated fats that exceeded set nutrient or calorie limits.¹⁸¹ On the impact of the Chilean law, Taillie et al found that the purchase volume of targeted beverages decreased by 22,8 millilitres per capita per day or 23,7 per cent, after implementation of the law.¹⁸² Massri et al found that as a result of implementation of the law, foods

Implications of psychological research for first amendment law' (2012) 10 *American Journal of Public Health* 214, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3483979/> (accessed 29 April 2020); B Reeve & R Magnusson 'Regulation of food advertising to children in six jurisdictions: A framework for analysing and improving the performance of regulatory instruments' (2018) 35 *Arizona Journal of International and Comparative Law* 72.

176 M Montana et al 'Food advertising and prevention of childhood obesity in Spain: Analysis of the nutritional value of the products and discursive strategies used in the ads most viewed by children from 2016 to 2018' (2019) 11 *Nutrients*, doi:10.3390/nu/1122873 (accessed 30 April 2020).

177 As above.

178 AMELEGALS 'India: Food safety and standards (advertising and claims) regulations – A deeper dive into compliance wef July 2019', <https://www.mondaq.com/india/healthcare/823582/food-safety-and-standards-advertising-and-claims-regulations-2018--a-deeper-dive-into-compliance-wef-july2019> (accessed 30 April 2019).

179 WHO 'Policy-Foodstuffs, Cosmetics and Disinfectants Act (54/1972): Regulations relating to the reduction of sodium in certain foodstuffs and related matters; amendment' <https://extranet.who.int/nutrition/gina/en/node/38491> (accessed 1 May 2020).

180 Law 20.606 of 2016.

181 LS Taillie et al 'An evaluation of Chile's law on food labelling and advertising on sugar-sweetened beverage purchases from 2015-2017' (2020) *Public Library of Science Medicine*, <http://doi.org/10.1371/journal.pmed.1003015> (accessed 1 May 2020).

182 As above.

exceeding cut-offs decreased from 90,4 per cent to 15 per cent in 2016.¹⁸³ Thus, Uganda needs legislation that controls or regulates the pervasive advertisement and marketing of sugar-sweetened beverages and other unhealthy food. Higher taxes should also be imposed on these food and beverages to make them less affordable.

Some of the food and beverages on the market may also be counterfeit. A recent study by the Uganda National Bureau of Standards (UNBS) found that 54 per cent of products on the Ugandan market, including food and cosmetics for women, are either counterfeit or substandard.¹⁸⁴ Parliament should debate and pass the Anti-Counterfeit Bill, 2015, after addressing concerns by civil society organisations that the proposed law may limit access to generic drugs which, because of their relative affordability, are essential in the treatment of NCDs. In order to enhance access to medicines, Parliament should also engage the government to utilise TRIPS flexibilities such as compulsory licensing and exploitation of patents by government, which were incorporated in the Industrial Property Act, 2014.¹⁸⁵

Parliament indeed can play a significant role in the promotion of the right to health by legislating against supply factors that exacerbate the NCD challenge. However, as the WHO and the United Nations Development Programme (UNDP) caution, legislators should be aware of the lobbying power of large tobacco, alcohol, food and beverages companies that are likely to thwart any efforts by Parliament to curtail their activities.¹⁸⁶ The WHO and the UNDP have outlined essential elements of legislation on tobacco control, the harmful use of alcohol, an unhealthy diet, physical inactivity and an unhealthy environment.¹⁸⁷ These include increasing taxes on tobacco, alcohol, and sugar-sweetened beverages; regulating advertising, the promotion and sponsorship of ultra-processed foods and beverages; and nutrition labelling on processed foods and beverages.¹⁸⁸ Civil society organisations (CSOs) engaged in tobacco control must hold government accountable to ensure that it resists

183 C Massri et al 'Impact of the food labelling and advertising law banning competitive food and beverages in Chilean public schools 2014-2016' (2019) 109 *American Journal of Public Health* 1294, DOI:10.2105/AJPH.2019.305159 (accessed 1 May 2020).

184 D Wandera '54% of goods on market fake – UNBS' *Daily Monitor* 1 August 2018, <http://www.monitor.co.ug> (accessed 10 May 2019).

185 Secs 58-67. On TRIPS and access to medicines, see BK Twinomugisha 'Implications of the TRIPS agreement for protection of the right of access to medicines in Uganda' (2008) 2 *Malawi Law Journal* 253.

186 WHO & UNDP *What legislators need to know* (2018).

187 WHO & UNDP (n 186) 3-4.

188 As above.

the industry and dedicate resources to the effective enforcement of the Tobacco Control Act.

Tobacco control advocates should also be aware of the fact that tobacco companies are well-resourced and are litigious. Thus, there is a need for defence lawyers – usually government lawyers or state attorneys – to anticipate the likely arguments and strategies of the tobacco industry and to adequately prepare to counter them at an early stage. In order to augment efforts by government lawyers, CSOs, engaged in tobacco control advocacy, may also apply to court to be joined as parties to the suit. A person or professional, with experience in tobacco control strategies, may also apply to court for leave to join the suit as an *amicus curiae*. CSOs should engage the media to ensure that any ‘shady’ or suspect transactions involving the tobacco industry in respect of the suit are duly investigated and exposed. CSOs should sensitise judicial officers and lawyers about the provisions of the WHO Framework Convention on Tobacco Control and the Tobacco Control Act.

4.1.2 *Constitutional rights litigation*

Using examples from India, Columbia and the United States, Magnusson et al illustrate how constitutional rights provisions may be used to challenge actions or omissions by governments and corporations, which are harmful to health.¹⁸⁹ Litigation may be used to hold the relevant industry actors to account for harm caused by their health-related products.¹⁹⁰ The Constitution confers a right on any person who claims that a fundamental right or other freedom guaranteed under the Constitution has been infringed or threatened to petition a competent court for redress, including compensation.¹⁹¹ The Human Rights Enforcement Act, 2019, permits such a person to apply to the High Court for redress.¹⁹²

Indeed, some public-spirited individuals and organisations have challenged violations of health-related rights.¹⁹³ In *Centre for Health, Human Rights and Development & Others v Attorney-General*¹⁹⁴ the petitioners argued that the non-provision of maternal health care commodities in public health facilities violated human rights such as

¹⁸⁹ Magnusson et al (n 152).

¹⁹⁰ As above.

¹⁹¹ Art 50.

¹⁹² Secs 3 & 4.

¹⁹³ See eg *Centre for Health, Human Rights and Development & Others v Attorney-General* Constitutional Petition 16 of 2011; *Centre for Health, Human Rights and Development & Others v Nakaseke District Administration*, Civil Suit 111 of 2012.

¹⁹⁴ Constitutional Petition 16 of 2011.

the rights to life and health. The Constitutional Court dismissed the petition on the ground that it raised political questions into which the Court could not inquire. However, on appeal¹⁹⁵ the Supreme Court referred the case to the Constitutional Court to be determined on its merits. It held that courts have the constitutional mandate to inquire into socio-economic human rights such as the right to health beyond the strict interpretation of the doctrines of separation of powers and political question, and that courts can adjudicate matters of social policy decided by the political branches of the state, namely, the executive and the legislature.

Activities of tobacco companies have also been challenged through litigation using the right to a clean and healthy environment. In *Asiimwe & Others v Leaf Tobacco and Commodities (U) Ltd & Another*¹⁹⁶ the applicants alleged that the activities of the first respondent, which included tobacco processing, the emission of tobacco smoke, dust and smell, violated their right to a clean and healthy environment, which is guaranteed by the Constitution.¹⁹⁷ Counsel for the respondents raised a preliminary objection that there was no cause of action since the applicants had not suffered personal injury. The Court cited the cases of *British American Tobacco Ltd v The Environmental Action Network*¹⁹⁸ and *Advocates for Development and Environment v Attorney-General*,¹⁹⁹ where the Court held that the purpose of article 50(2) of the Constitution is to enable an individual or organisation to protect the rights of others, especially the indigent and vulnerable, although they have not suffered personal injury or a violation of their rights.²⁰⁰ The Court dismissed the preliminary objection and held that the respondents had violated the applicant's right to a clean and health healthy environment.

In yet another case, that of *BAT Uganda Limited v Attorney-General and Centre for Health, Human Rights and Development*,²⁰¹ the petitioner, a tobacco company, challenged the constitutionality of several provisions of the Tobacco Control Act, 2015, including those requiring large picture health warnings, the banning of smoking in public places and workplaces, the banning of all tobacco advertising, promotion and sponsorship, and the prohibition of the

195 Constitutional Appeal 1 of 2013.

196 Miscellaneous Application 43 of 2013.

197 Art 39.

198 Miscellaneous Application 27 of 2003.

199 Miscellaneous Cause 100 of 2004.

200 For a detailed discussion of these cases, see BK Twinomugisha 'Some reflections on judicial protection of the right to a clean and healthy environment in Uganda' (2007) 3 *Law, Environment and Development Journal* 246, <http://www.lead.jurnal.org/content/07244.pdf> (accessed 1 May 2020).

201 Constitutional Petition 46 of 2016.

sale of tobacco products in specified places. The petitioner argued that these provisions, among others, violated the right to practise a lawful trade, business or occupation.²⁰² The Court held that the petitioner's rights were not absolute since they can be limited in the public interest, which includes the protection of public health.²⁰³ Owiny-Dollo DCJ held as follows:²⁰⁴

This petition, I have no doubt in my mind is part of a global strategy by the petitioner and others engaged in same or related trade to undermine legislation in order to expand the boundaries of their trade and increase their profits irrespective of the adverse health risks their products pose to human population ... The petitioner admits that its products when used in accordance with their instructions result into serious adverse effects to their users and others. They also concede that the products they manufacture and sell cause death. Legislation such as the Tobacco Control Act that seeks to protect the public from the adverse effects of the petitioner's products cannot be said to be unconstitutional.

There have also been attempts at challenging the activities of food and beverage companies. In *Centre for Food and Adequate Living v Attorney-General & Another*,²⁰⁵ which has not yet been decided, the applicants allege that the government's failure and omission to restrict the marketing, broadcasting and advertisement of unhealthy foods to children is a violation of the rights to adequate food, health and safety of the children. The applicants are asking the Court for orders, among others, banning the marketing, broadcasting and advertisement of unhealthy food to children.

4.2 Community participation in the prevention and treatment of non-communicable diseases

Participation, which is a cardinal component of the right to health, is recognised in various international, regional and national human rights instruments.²⁰⁶ Participation in the context of this discussion means that citizens have genuine ownership and control over NCD policy development processes at all stages: analysis, design, planning, implementation, monitoring and evaluation. Participation

202 Art 40(2).

203 Art 43 of the Constitution.

204 *BAT Uganda Ltd case* (n 201) 53.

205 Miscellaneous Cause 436 of 2019.

206 Art 21 Universal Declaration; art 25 ICCPR, art 8 ICESCR; arts 7, 8 & 14 CEDAW; arts 4(3), 29 & 33(3) CRPD; and art 13 African Charter. See also arts 1 and 2 of the UN Declaration on the Right to Development, adopted by the UN General Assembly Resolution 41/128 of December 1986; WHO Declaration on Alma-Ata; International Conference on Primary Health Care, Alma-Ata, USST, 6-12 September 1978; and art 38 of the Constitution.

entails active and genuine involvement of citizens in identifying their problems and designing appropriate interventions through collaboration with different stakeholders, including government and its relevant agencies. Thus, participation in the prevention, treatment and management of NCDs does not mean that citizens should depend entirely on their own resources without external support. Government should marshal, invest and direct financial, human and other resources, including seeking international assistance, for integrated preventive and curative care in the context of NCDs and in the spirit of primary health care. Building on their resilience, ingenuity and agency, citizens should be empowered with relevant public health education and information so that they may demand accountability from the state and non-state actors involved in NCD-related programmes. Genuine and active participation should promote citizens' consciousness and awareness of their human rights, including the right to health, to enable them to express their views, interests, grievances and concerns towards the state and other duty bearers.

The challenges posed by neo-liberalism in the context of NCDs are not insurmountable. Building on the philosophy informing the Alma-Ata Declaration,²⁰⁷ government should look at neo-liberal economic policies not only in terms of how they promote economic growth but how they impact on the health and welfare of the people. It should devise health policies that lead to the empowerment of the population and facilitate their active participation. However, as the experiences of China²⁰⁸ and Mexico²⁰⁹ illustrate, for a community participation approach in tackling NCDs to be effective, there should be enhanced support for education, information and communication interventions in the community. Community health centres, especially Health Centres III and IV, should be utilised in NCD detection, diagnosis, treatment and management. The government should create incentives, including transport costs and accommodation, in order to attract a greater number of qualified health professionals at all levels, including in areas that are difficult to reach. Village health teams, which are focused largely on infectious diseases and maternal-child health, might be utilised by health professionals in

207 Alma-Ata Declaration (n 206).

208 N Xiao et al 'A community-based approach to non-communicable chronic disease management within the context of advancing universal health coverage in China: Progress and challenges' (2014) 14 *BMC Public Health*, <https://doi.org/10.1186/1471-2458-14-S2-S2> (accessed 21 April 2019).

209 K Duan et al 'Implementation and clinical effectiveness of a community-based non-communicable disease treatment programme in rural Mexico: A difference-in-differences analysis' (2018) 33 *Health Policy and Planning* 707, <https://doi.org/10.1093/heapol/czy041> (accessed 18 April 2019).

community prevention and the management of NCDs.²¹⁰ There should be an increased investment in public healthcare goods and services, including essential medicines, at all health centres. This entails that government should increase its expenditure on health to the target of 15 per cent as agreed in 2001 by African Union (AU) countries in Abuja to ensure that primary health care is prioritised.²¹¹

The right to participation additionally requires that communities should be able to determine which food to produce and the farming methods and techniques. Participation implies that food sovereignty, and not necessarily the commercialisation of agriculture, should be promoted. Food sovereignty has been defined as

the right of peoples to healthy and culturally appropriate food produced through ecologically sound and sustainable methods, and [people's] right to determine their own food and agricultural systems. It puts the aspirations and needs of those who produce, distribute and consume food at the heart of food systems and policies rather than the demands of markets and corporations.²¹²

Food sovereignty goes beyond ensuring that people have enough food to meet their physical needs.²¹³ People should be empowered to produce and enjoy healthy and culturally-appropriate food. Their local production systems should be promoted and supported. Rural women should have power over the seed and be able to pass it over from one generation to the next. Trade liberalisation of seed production, which favours transnational corporations such as Monsanto, should be revisited. Fast food may be dangerous to a person's health. Thus, local, traditional and organic food production and consumption should be prioritised, encouraged, promoted and supported. The state should, through land reform, ensure that peasants and landless people have access to land. They should be empowered to demand seeds and access to water as a public good.

4.3 A gender perspective in non-communicable disease prevention and management interventions

According to Vlassof, the concept of gender 'refers to the array of socially-constructed roles and relationships, personality traits,

210 T Ojo et al 'Exploring knowledge and attitudes toward non-communicable diseases among village health teams in Eastern Uganda: A cross-sectional study' (2017) 17 *BMC Public Health*, <https://doi.org/10.1186/s12889-017-4954-8> (accessed 23 April 2019).

211 OAU 'Abuja declaration on HIV/AIDS, tuberculosis and other related infectious diseases' OAU/SPS/ABUJA/3 (2001) para 26.

212 See Declaration of Nyeleni, Global Forum on Food Sovereignty, Mali, 2007, <https://nyeleni.org/spip.php?article290> (accessed 10 February 2020).

213 As above.

attitudes, behaviours, values, relative power and influence that society ascribes to the two sexes on a differential basis'.²¹⁴ The WHO defines gender in terms of 'the roles, behaviours, activities, attributes, and opportunities that any society considers appropriate for girls and boys, and women and men'.²¹⁵ The gender perspective is critical in analysing how public health challenges such as NCDs affect women and men in the era of neo-liberalism. The perspective is also crucial in assessing how government responds to these challenges. In fact, the ESCR Committee has urged states parties to

integrate a gender perspective in their health-related policies, planning and research in order to promote better health for both women and men. A gender-based approach recognizes that biological and socio-cultural factors play a significant role in influencing the health of men and women. The disaggregation of health and socio-economic data according to sex is essential for identifying and remedying inequalities in health.²¹⁶

Studies have found that women and men have different levels of exposure and vulnerability to NCD risk factors.²¹⁷ The WHO observes that NCDs are the leading cause of death among women globally and are responsible for two in every three deaths among women annually.²¹⁸ The role of women in the household may expose them to air pollution – an important contributing risk factor to NCDs.²¹⁹ According to the WHO, household air pollution causes NCDs, including respiratory disease and lung cancer.²²⁰ According to USAID, 'due to their domestic roles, women and girls tend to be more exposed to the smoke, dust and soot caused by cooking solid fuels'.²²¹ They are exposed to second-hand smoke, which is a known risk factor for NCDs.²²² Pregnant women may also experience a series of NCDs related to their reproductive functions, for example, an increase in blood pressure.²²³

214 C Vlassoff 'Gender difference in determinants and consequences of health and illness' (2007) *Health Population Nutrition Journal* 47.

215 WHO 'Gender', www.who.int/health-topics/gender (accessed 11 February 2020).

216 Para 20, General Comment 14.

217 See eg WHO *Women and the rapid rise of non-communicable diseases* (2020); WHO *Non-communicable diseases: A priority for women's health* (2011); Ministry of Health *Non-Communicable Disease Risk Factor Baseline Survey* (2014); WHO *Non-communicable diseases: A priority for women's health and development* (2011).

218 WHO *Global coordination mechanism on the prevention and control of NCDs* (2020), <http://who.int/global-coordination-mechanism/ncd-themes/NCD-and> (accessed 1 May 2020).

219 WHO *Household pollution and health* (2018).

220 As above.

221 USAID *Addressing the unique needs of men and women in non-communicable disease services* (2011) 2.

222 As above.

223 See eg L Hinkosa et al 'Risk factors associated with hypertensive disorders in pregnancy in Nekemte referral hospital from July 2015 to June 2017, Ethiopia:

USAID has observed that gender relations ‘affect accessibility to preventive care and treatment for NCDs’.²²⁴ The underlying ‘gender-related power inequalities have implications for NCD treatment, as women and girls may depend on their husbands or partners for health care decision-making, access and expenditures’.²²⁵ Although studies reveal that women are more likely to seek health care than men, other factors such as income poverty may inhibit their access to health care.²²⁶ Women experience fewer apparent symptoms of cardiovascular diseases than men and, consequently, are less likely to be diagnosed and treated.²²⁷ The majority of the world’s poor are women, who are least able to afford funds for NCD treatment. When a household has money available for health care, these funds may be spent on men’s health needs.²²⁸ Women may also have an unequal say in decisions pertaining to health expenditures.²²⁹ Women often are sole caregivers for those with NCDs and their care-giving and other types of informal work are unpaid or underpaid. This situation may be exacerbated by neo-liberal policies that impose charges for health care, including NCD prevention, treatment, care and support.

Thus, integrating a gender perspective in health interventions is critical since NCDs affect men and women differently. There are even gender-specific NCDs, which require specifically-designed interventions. For example, while some women suffer from cervical cancer, prostate or testicular and penile cancers are specific to men. Thus, as USAID has recommended, it is critical that data should be collected for men and women disaggregated by sex, and analysed through a gender perspective.²³⁰ Policies and other interventions based on this data should address the different NCD prevention, screening, treatment and management needs of men and women. All these policies and interventions should be guided by the right to health framework.

Case control study’ (2020) 16 *BMC Pregnancy and Child Birth* 20; A Nakimuli et al ‘The burden of maternal morbidity and mortality attributable to hypertensive disorders in pregnancy: A prospective cohort study from Uganda’ (2016) *BMC Pregnancy and Childbirth* 16.

224 As above.

225 As above.

226 Centre for Disease Control and Prevention ‘The health consequences of smoking: 50 years of progress’, <https://www.surgeongeneral.gov/library/reports/50-years-of-progress/full-report.pdf> (accessed 10 April 2019).

227 HA de Von et al ‘Symptoms across the continuum of acute coronary syndromes: Differences between women and men’ (2008) 17 *American Journal of Critical Care* 14.

228 BK Twinomugisha ‘Protection of rural poor women’s right of access to maternal health care in Uganda: The case of Kashambya sub-county’ unpublished LLD thesis, Makerere University, 2005 102.

229 As above.

230 USAID (n 221) 3.

5 Conclusion

The main objective of the article was to reflect on how the right to health framework may be used to tackle non-communicable diseases in the era of neo-liberalism in Uganda. The state has obligations to respect, protect and fulfil the right to health. As part of its obligation to protect human rights, the state should ensure that activities by private persons, including tobacco, alcoholic, food and beverage industries, do not adversely affect the realisation of the right to health. The state should devise juridical, administrative and other appropriate measures to ensure that activities of these industries do not escalate the NCD trajectory in the country. Such measures should target unhealthy commodity industries as the major drivers of NCDs through regulation, taxation, pricing, product bans, and restrictions on advertising and sponsorship.

Current prevention, control and management efforts that frame the question of NCDs as apolitical by focusing primarily on individual behaviour or lifestyle changes are likely to fail unless structural factors that shape the NCD burden are tackled. Prevention measures through lifestyle changes are critical for the patient and health system. A person's choice and behaviour play a crucial part in explaining the outset of NCDs. However, the political, economic and social context in which the diseases are located and reproduced cannot be ignored. The role of the social determinants of health, including poverty, gender and social inequalities, the level of education, nutrition, and environmental conditions, should be recognised. The contribution of processes such as trade liberalisation and the marketing activities of transnational corporations to the burden of NCDs should also be recognised.

Under neo-liberalism, public health has been moved into the private sphere. The state must intervene and reclaim its place in the socio-economic sphere. Neoliberal policies of privatisation and liberalisation should be revisited. In the absence of social protection measures and other safety nets, there is an urgent need to treat health as a public good especially for the poor and vulnerable – those who cannot by their own means afford the high cost of NCD-related care. Heavily-subsidised universal health insurance may also be considered. The production and consumption of locally-produced organic foods should be promoted. Thus, the food sovereignty of the people should be promoted. Small-scale farmers should be supported with the necessary agricultural implements to enable them produce sufficient food for their families. The government may even consider the delicate and complex question of land redistribution to ensure

that peasants, rural women and landless people have access to and control of land for food production.

Gender relations affect accessibility to preventive care and treatment for NCDs. The underlying gender-related power relations and inequalities have implications for NCD prevention and treatment. Thus, a gender perspective should be incorporated in all health policies and other interventions since NCDs may affect men and women differently. Communities should be empowered to ensure that they may meaningfully participate in NCD related interventions.