Chapter 12: Enabling environments to support healthy and safe behaviours

SUMMARY POINTS

- Noncommunicable diseases (NCDs) kill more than 38 million people every year. Three quarters of these deaths occur in low- and middle-income countries, entrenching poverty, cutting into the productive years of life and undermining the benefits of the lower dependency rates enjoyed by developing countries with younger populations.

- Members of the World Health Assembly have committed to a 25% relative reduction in premature mortality from cardiovascular diseases, cancer, diabetes and chronic respiratory diseases by 2025, and to a set of supporting targets covering key risk factors: harmful use of alcohol, physical inactivity, salt intake, tobacco use, raised blood pressure, and overweight and obesity. The WHO Global Action Plan for the Prevention and Control of NCDs identifies a suite of policy options to assist countries to meet these targets.

- Many of WHO’s recommended “best buys” for reducing risk factors for NCDs will require legal and regulatory controls for effective implementation. To ensure that these measures are implemented, with adequate budgets for monitoring and enforcement, high-level leadership will be required from presidents, prime ministers, health ministers and other senior cabinet ministers. The involvement of non-health ministries is vital, since many of the most important interventions will be implemented outside the health sector. Examples include raising taxes on alcohol and/or unhealthy food and beverages, reducing the amount of smuggled and counterfeit tobacco products, and restricting the marketing of unhealthy foods to children.

- When implementing effective measures to prevent and control NCDs, governments can expect resistance from manufacturers and retailers of tobacco, alcohol and unhealthy foods, and their allies. The tobacco and alcohol industries should have no role in the formation of tobacco and alcohol control laws and policies.

- Where voluntary partnerships with the food industry are ineffective in achieving national targets, governments may consider strengthening their level of oversight of the industry, and implementing a co-regulatory approach.

- Governments have a responsibility to disseminate accurate information about health risks to their populations and to promote healthy lifestyles. Independent health promotion agencies, established by legislation, are one model for providing national leadership in health promotion.

- Injuries claim nearly 5 million lives each year and are a neglected global health priority. Ninety per cent of fatal injuries occur in low- and middle-income countries.

- Law has an important role to play in reducing road traffic injuries, including through setting and enforcing speed limits on roads, regulating the licence system, implementing drink-driving counter-measures (e.g. random breath testing), and requiring seat belts to be used by all occupants of motor vehicles and helmets to be worn on motorcycles and bicycles.
Introduction

Enabling individuals to make healthy choices and to engage in safe behaviours is a core function of public health law. Individual behaviour is a significant contributor to avoidable death and disability, both from noncommunicable diseases (NCDs) and injuries. The most prominent NCDs (cardiovascular disease, cancer, diabetes and chronic respiratory diseases) are linked to a cluster of behavioural risk factors including tobacco use, harmful use of alcohol, unhealthy diets and lack of physical activity. In 2012, NCDs caused 38 million deaths. Nearly three quarters of these deaths (28 million), and over 80% of premature deaths, occurred in low- and middle-income countries. Injuries and violence accounted for a further 5 million deaths.

To the extent that they have the knowledge and resources to do so, individuals share responsibility for the choices they make about their health and lifestyles. At the same time, governments have an over-riding responsibility to seek to realize the right to health for the populations they represent (see Section 1.1). Public health laws can significantly reduce the occurrence of injuries and the preventable component of NCDs by helping to create environments that are safer and that support healthier behaviours. This section identifies priority areas where law can support governments and individuals to reduce risks from NCDs and injuries.

12.1 Enabling behaviours that reduce risks for NCDs

WHO has identified four modifiable behavioural risk factors that are responsible for most NCDs: tobacco use, lack of physical activity, unhealthy diet and harmful use of alcohol. These risk factors contribute to metabolic and physiological risk factors including raised blood pressure (which alone was responsible for over 9 million deaths in 2010), overweight and obesity, high blood glucose levels (hyperglycaemia), and high cholesterol. NCDs and their risk factors occur at higher rates among those with lower levels of income and education, entrenching poverty, cutting into the productive years of life and undermining the benefits of the lower dependency rates enjoyed by developing countries with younger populations.

NCDs impose heavy economic costs on households, health systems and economies due to a range of factors including reduced labour supply, reduced productivity, higher demand for medical treatments, and higher social welfare expenditures. According to a study prepared for the World Economic Forum, under a “business as usual” scenario, NCD morbidity and mortality will cost low- and middle-income countries US$ 500 billion per year over the period 2011–2025 (roughly 4% of average gross domestic product). On the other hand, cost-effective interventions are available. WHO has estimated that the cost of implementing a core set of population-level and individual-level interventions for preventing and treating NCDs (including the cost-effective “best buys” indicated in Table 12.1), would require an annual investment of US$ 1 per person in low-income countries, US$ 1.50 in lower middle-income countries, and US$ 3 in upper-middle-income countries.
(a) Global targets for reducing mortality from NCDs

In 2012, at the World Health Assembly (WHA), WHO Member States adopted a global target of a 25% relative reduction in mortality from cardiovascular diseases, cancer, diabetes and chronic respiratory diseases by 2025. In 2013, the WHA adopted a global monitoring framework that included eight additional voluntary targets for reducing risk factors and improving the response of national health systems, and 25 indicators for measuring progress towards each target. These targets include a 10% relative reduction in the harmful use of alcohol; a 10% relative reduction in the prevalence of insufficient physical activity; a 30% reduction in mean population salt intake; a 30% relative reduction in prevalence of current tobacco use; and a halt in the rise of diabetes and obesity. A progress report was submitted to the WHA in 2015, and further reports will be submitted in 2020 and 2025.

Following the high-level meeting on the prevention and control of NCDs held by the United Nations General Assembly (UNGA) in September 2011, the UNGA has also become a forum for global action on NCDs. For example, in 2014, members of the UNGA made a number of time-bound commitments; these included the commitment to consider setting national targets and process indicators, taking into account the nine voluntary targets adopted by the WHA, and to consider developing or strengthening a national multisectoral coordinating mechanism to achieve these national targets. Members of the UNGA have also assumed reporting obligations to facilitate the preparation, by WHO, of reports to the UNGA on progress achieved in the prevention and control of NCDs. Separately, members of the UNGA have adopted 17 Sustainable Development Goals (SDGs) and 169 supporting targets in order to accelerate sustainable development over the period 2015–2030. The Sustainable Development Goals include the following target: to “reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being” (Target 3.4).

(b) Implementing “best buys” for NCDs

The WHO Global Action Plan for the Prevention and Control of NCDs 2013–2020 identified a suite of policy options to assist countries to meet these targets. A number of these policies are “best buys”, meaning that they are very cost-effective and affordable in low- and middle-income countries. As Table 12.1 illustrates, the implementation of priority actions for the prevention and control of NCDs may require fiscal policies by governments (e.g. raising taxes) or new legislation or regulations that prescribe standards, mandate required actions and authorize government agencies to carry out monitoring and enforcement. Specific legal strategies for reducing tobacco use and obesity are discussed in Chapters 13 and 16 of this report.

Fully implementing the legal and regulatory priorities included in Table 12.1 is likely to be challenging in some countries, due to the political influence of tobacco, alcohol and processed food manufacturers and retailers. In order to secure the passage of the laws, policies and budgets that are needed, high-level leadership will be needed from presidents, prime ministers, health ministers and other political leaders. While leadership within the health ministry will be vital, the involvement of other ministries is also necessary, since many of the priority interventions will be implemented outside the health sector. Governance processes will be required to coordinate the work of all
relevant ministries, including health, agriculture, finance and taxation, education, recreation and sport, media and communications, transport and urban planning. Coordinating mechanisms are necessary to mediate tensions between ministries and to ensure that all ministries work constructively towards common goals (see Section 6.3).

Table 12.1 Selected legal and regulatory priorities for reducing risk factors for NCDs

(Best Buy = ✓)

<table>
<thead>
<tr>
<th>Tobacco</th>
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<td>Comprehensive implementation of the WHO Framework Convention on Tobacco Control (WHO FCTC), especially:</td>
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<td>● Reducing the affordability of tobacco products by increasing tobacco excise taxes (WHO FCTC, Article 6) ✓</td>
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<td>● Banning smoking in public places, including workplaces, public transport, bars and restaurants (WHO FCTC, Article 8) ✓</td>
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<td>● Health warnings on tobacco products, and at point of sale; labelling controls (WHO FCTC, Articles 11 and 12) ✓</td>
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<td>● Comprehensive bans on all forms of tobacco advertising, promotion and sponsorship, including in all media, in community settings, and in retail establishments (WHO FCTC, Article 13) ✓</td>
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<td>● Bans on sales of tobacco by and to persons under the age of 18 years, or the age set by domestic law, with monitoring and enforcement (WHO FCTC, Article 16)</td>
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<td>● Penalties for smuggled and counterfeit tobacco, with adequate resources for monitoring and enforcement (WHO FCTC, Article 15; Protocol to Eliminate Illicit Trade in Tobacco Products)</td>
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<td>● Affordable treatment for tobacco dependence: supporting interventions for smoking cessation in primary care; affordable pharmacological therapies (WHO FCTC Article 14)</td>
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<th>Alcohol</th>
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<td>Implementation of the WHO Global Strategy to Reduce the Harmful Use of Alcohol, especially:</td>
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<td>● Increasing excise taxes on alcoholic beverages (paras 32–34) ✓</td>
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<td>● Strengthening tracking systems for illicit alcohol, with penalties for smuggled and informal alcohol, and adequate resources for monitoring and enforcement (paras 37–39)</td>
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<td>● Restricting or banning alcohol advertising and promotion through the media, including social media, in community settings and retail establishments; restrictions on alcohol sponsorship of cultural and sporting events (paras 29–31) ✓</td>
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<td>● Controls on access to retailed alcohol, including minimum age purchasing laws, licensing and other controls on days and hours of retail sale, location and density of retail outlets (paras 27–28) ✓</td>
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<tr>
<td>● Health warnings on alcohol products and at point of sale; enforce laws against serving to intoxication, and legal liability for harm that results from intoxication following the service of alcohol (paras 19 and 36)</td>
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<td>● Drink-driving counter-measures, including random breath testing, a maximum 0.5 g/l blood alcohol concentration limit for adult drivers, with a reduced or zero limit for younger drivers (paras 24–26)</td>
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1 The Protocol was adopted on 12 November 2012 at the fifth session of the Conference of the Parties to the WHO FCTC, but at the time of writing had not yet entered into force.
Building on the WHO Global Strategy on Diet, Physical Activity and Health:\(^2\)

- Institutional and governance reform to enable development of a comprehensive and multisectoral approach to policy development for diet, nutrition and physical activity, with input from key sectors (agriculture, transport, education, environmental and urban planning, sport, youth, industry, finance, and media and communications). City and local governments should have a legal mandate to play a leading role (paras 38–44)

- Review agricultural policies to ensure they contribute to a healthy and sustainable food supply (para. 41)

- Encourage or require food reformulation in order to reduce levels of salt, saturated fat and added sugar (para. 41)

- Requiring food manufacturers to replace trans-fats with polyunsaturated fats (para. 41)

- Place restrictions on the marketing of foods and beverages high in salt, sugar and fats (especially to children): WHO, resolution WHA 63.14 (adopted in May 2010) on marketing of foods and non-alcoholic beverages to children

- Implement a framework for food labelling and health claims on food products to support healthy choices and to prevent misleading claims about food (para. 40)

- Manage food taxes and subsidies to encourage a healthy diet; for example, by imposing higher taxes for foods and beverages to be consumed in lower quantities, and consider using revenues to support greater access to healthy foods among disadvantaged communities (para. 41)

- Legislation to protect women’s right to breastfeed, without harassment or discrimination

### Other strategies

- Hepatitis B vaccination

**c) Engaging with the private sector**

The implementation of legal and regulatory priorities for NCDs will necessarily affect the interests of the private sector, including manufacturers and retailers of tobacco products, alcoholic beverages, and nutritionally-poor foods and beverages. As discussed in Section 13.6, Article 5.3 of the Framework Convention on Tobacco Control (WHO FCTC) requires parties to protect the setting and implementation of their tobacco control policies from the commercial and vested interests of the tobacco industry.\(^2\) The Conference of the Parties to the WHO FCTC has issued guidelines to assist parties to implement their recommendations under Article 5.3.\(^2\)

Similarly, in light of evidence that the alcohol industry seeks to use partnerships to weaken national policies for alcohol control,\(^2\) WHO has emphasized that “the development of alcohol policies is the sole prerogative of national authorities”\(^2\) and that governments should take care to “protect the formulation of health policies from distortion by commercial or vested interests”.\(^2\)

In some countries, food manufacturers, retailers, government and public health stakeholders are engaged in voluntary partnerships to reformulate food products and to reduce levels of salt, saturated fat and sugar over time.\(^1\) In circumstances where voluntary processes fail to make timely progress towards public health goals and targets, governments may consider adopting a responsive regulatory approach that includes strengthening their level of oversight of the industry, “scaffolding”...
(d) Supporting health promotion

Health promotion campaigns to build adult literacy and public awareness about healthy behaviours are an important component of a comprehensive response to NCDs and their risk factors. The right to health imposes a duty on states to disseminate “appropriate information relating to healthy lifestyles and nutrition, harmful traditional practices and the availability of services”, and to support people in making informed choices about their health. Similarly, the WHO Global Strategy on Diet, Physical Activity and Health encourages governments to develop national dietary and physical activity guidelines and to ensure the availability of health promotion and education programmes.

Evidence-based recommendations include the following:

- limit energy intake from total fats and shift fat consumption away from saturated fats to unsaturated fats and towards the elimination of trans-fatty acids;
- increase the consumption of fruits and vegetables, and legumes, whole grains and nuts;
- limit the intake of free sugars;
- limit salt (sodium) consumption from all sources and ensure that salt is iodized; and
- engage in at least 30 minutes of regular, moderate-intensity physical activity on most days.

Independent agencies dedicated to health promotion can provide an important institutional base for national campaigns to quit smoking, reduce the harmful use of alcohol, reduce dietary risk factors and promote physical activity. For example, in 2007, in response to a rapidly escalating NCD crisis, Tonga passed legislation to establish a national Health Promotion Foundation (also known as TongaHealth). The Foundation is an independent body that works with communities, nongovernmental organizations and government departments to promote healthy lifestyle changes throughout Tonga. It acts as a catalyst for the development of new policies, programmes and environments, designs and conducts social marketing campaigns, and administers a competitive grant scheme that funds research, programmes and facilities to promote health and reduce NCD risk factors. Members of the Board of the Foundation are appointed by an appointment committee that consists of the Minister for Health, the Chair of the National Noncommunicable Diseases Committee and its sub-committees. The existence of an independent statutory agency may be helpful in ensuring that health promotion receives the budgetary resources it needs within the overall health portfolio. Tonga’s example has been helpful in influencing other South Pacific countries to establish similar agencies.
12.2 Discouraging behaviour that contributes to injuries

Injuries claim nearly 5 million lives each year: around 9% of global deaths. One quarter of these deaths are caused by road traffic injuries, the ninth leading cause of death in 2012, and the leading cause of death for people aged 15–29 years. Road traffic injuries cost low- and middle-income countries over US$ 100 billion annually (between 1% and 2% of gross national product), and are increasing in many countries due to rapid motorization coupled with the failure to invest in proven road safety interventions.

WHO has recommended that countries develop national strategies for preventing road traffic injuries, and designate a single agency or focal point with responsibilities in this area. These responsibilities should include collaborating with other ministries and stakeholders, including transport companies and the community. Law plays an important role in improving road safety. Key areas for law reform may include: setting and enforcing speed limits on roads, introducing traffic-calming measures, introducing and enforcing offences for driving while intoxicated, introducing a graduated licensing system (with mandatory speed restrictions) for novice drivers, prohibiting drivers from using hand-held electronic devices while driving, requiring motorcycles to use running lights during daytime, and mandating the use of seat belts and child restraints in cars, and helmets by people using motorcycles and bicycles. In countries where alcohol use is not condoned, significant hidden consumption may nevertheless occur, and paradoxically there may be limited public awareness of the hazards of drink-driving.

The Islamic Republic of Iran experienced a significant decline in fatal traffic accidents and injuries between 1997 and 2007, following the passage of a law that required the government to develop road safety legislation within a period of six months (see Box 12.1). Laws requiring the use of safety belts for drivers and all passengers of four wheeled vehicles save lives during traffic accidents, are highly cost-effective, and can be successfully implemented in rapidly motorizing low and middle-income countries.

Box 12.1: Reducing the risk to health from traffic accidents: an example from the Islamic Republic of Iran

| The Government is charged with preparation of a bill for protection and enhancement of health of the individual members of society and reduction of the risks to health, including through the following points, and to present the said bill to the Islamic Consultative Assembly for approval, within six months of enactment of this law: |
| • Reducing traffic accidents, through reconnaissance of accident-generating points and axes along roads and highways ... and reducing the number of such points by 50% by the end of the fourth plan. |
| • Placing emphasis on the principles of safety and safe driving regulations. |
- Regulating and completing the pre-hospital and hospital medical emergency networks of the country and reducing the death tolls resulting from traffic accidents by 50% by the end of the fourth plan.
- Enhancing the safety plan for motor vehicles and enforcing human and safety engineering standards.

In one intervention carried out in the Chinese city of Guangzhou, four strategies for reducing road traffic injuries were implemented over a 12-month period. These included enhanced police training, highly visible police patrols, as well as static, covert operations at different locations throughout the city and social marketing (radio and television commercials, billboards, bus signs). Courses or materials concerning the requirement to fit and use seat belts, and the safety benefits, were provided to taxi company managers, instructors in driving schools and primary school teachers. Over the period of the intervention, the prevalence of seat-belt use by drivers and passengers increased by 12%, reducing serious injuries and fatalities by 7%. Interventions like this are highly cost-effective in reducing the cost of road traffic accidents in rapidly motorizing societies.

Among motorcyclists, research shows that mandatory helmet laws are highly effective in reducing deaths from traffic accidents as well as non-fatal traumatic brain injury. In Viet Nam, a national helmet law in effect from December 2007 increased helmet use up to 99% and avoided 1557 deaths and 2495 serious injuries in its first year of operation (Box 12.2). In Romagna, Italy, hospital admissions for traumatic brain injury decreased by 31% in the year following introduction of the mandatory motorcycle helmet law. Experience has shown that the repealing of mandatory motorcycle helmet laws is associated with sharp increases in rates of motorcycle fatalities.

Box 12.2: Reducing death and disability from motor vehicle accidents in Viet Nam through a national motorcycle helmet law

**Reasons for the success of Viet Nam’s law included the following:**

- Significant penalties were set for failing to wear a helmet;
- Public education and social marketing increased public awareness prior to the introduction of the new law. Civil service employees and members of the armed services wore helmets three months before the law took effect;
- The law was strictly enforced from the date it came into effect;
- The obligation imposed was simple to understand: the helmet law applied to all motorcycle riders and all passengers on all roads;
- Supported by government product standards to prevent substandard products entering the market, high-quality, climatically appropriate helmets were widely available for sale at an affordable price, and 50 000 helmets were distributed to low-income families;
- The mandatory helmet law was issued by the Prime Minister. This ensured the highest level of political support. A multisectoral National Traffic Safety Committee, chaired by the Minister of Transport, with representatives from 15 ministries, led the development and implementation of the law on behalf of the Vietnamese government.
REFERENCES

16 Technical note: how WHO will report in 2017 to the United Nations General Assembly on the progress achieved in the implementation of commitments included in the 2011 UN Political Declaration and 2014 UN

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Advancing the right to health: the vital role of law


36 Health Promotion Foundation Act 2007 (Tonga).

37 About us [website]. Nuku’alofa: Tonga Health Promotion Foundation (http://www.tongahealth.org/#!about_us/csgz); Health Promotion Foundation Act 2007 (Tonga) ss. 5, 15.

38 Health Promotion Foundation Act 2007 (Tonga) s. 8.


