



General Assembly

Distr.: General
14 July 2023

Original: English

Seventy-eighth session

Item 73 (b) of the provisional agenda*

Promotion and protection of human rights: human rights questions, including alternative approaches for improving the effective enjoyment of human rights and fundamental freedoms

Food, nutrition and the right to health

Note by the Secretary-General

The Secretary-General has the honour to transmit to the General Assembly the report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Tlaleng Mofokeng, submitted in accordance with Human Rights Council resolution [51/21](#).

* [A/78/150](#).



Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Tlaleng Mofokeng

Summary

In the present report, the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Tlaleng Mofokeng, focuses on food, nutrition and the right to health. She analyses access to food and nutrition and related clinical and health outcomes, and their reflection of power asymmetries, policy and regulatory frameworks.

Using the frameworks of intersectionality, anti-coloniality and anti-racism, as well as existing international human rights laws and standards, the Special Rapporteur examines how the lack of access to safe and nutritious food has an impact on growth, development and quality of life across the life cycle. She also identifies how increased consumption of unhealthy foods and beverages has driven the burden of non-communicable diseases such as diabetes and cardiovascular disease. Furthermore, she focuses on good practices in different parts of the world and encourages a comprehensive approach to the triad of food security, nutrition and the right to health.

I. Introduction

1. Food is a powerful expression of both self and community, embodying cultural, political and economic values.¹ It is often a “vehicle for transmitting cultural traditions and identities, especially when a group is marginalized by race, ethnicity, language or religion”,² and is also a central pawn in the political and economic strategies of States, corporations and households,³ intrinsically linked to social hierarchies and power asymmetries.⁴

2. Everyone is entitled to the highest attainable standard of physical and mental health, which extends to the underlying determinants of health, including an adequate supply of safe and nutritious food (see [E/C.12/2000/4](#), paras. 4, 11 and 12). Food insecurity, or the lack of regular access to adequate, safe and nutritious food for normal growth and development and an active and healthy life,⁵ affects more than 2.4 billion people, 800 million of whom experience hunger.⁶ Moreover, increased consumption of unhealthy foods and beverages, which have excess sugar, sodium or fats and often undergo high levels of processing, has driven up the burden of diet-related non-communicable diseases such as diabetes, cardiovascular disease and cancer (see [A/HRC/26/31](#)), now the leading causes of death across the globe.⁷

3. While lower-income countries are facing higher rates of both hunger and diet-related non-communicable diseases, the most marginalized individuals and communities within all societies are shouldering the greatest burdens of all forms of malnutrition, even within wealthy nations. Inequities reflect historic and lasting patterns of discrimination and disempowerment based on race, ethnicity, class, sex and gender, among others. Indigenous Peoples, women, children and infants face significantly higher risks of malnutrition and related health outcomes.⁸

4. Corporations headquartered in higher-income countries extract valuable natural resources for food production from lower-income countries, often displacing Indigenous and rural populations from their land and disrupting traditional means of food production, in order to flood their markets with unhealthy foods and beverages.⁹ Such practices constitute a manifestation of neocolonialism, racism, cultural erasure and extractive capitalism.

5. The present report will examine how inequities in food, nutrition and related clinical and health outcomes reflect power asymmetries at every level of society. Tackling such inequities requires a rights-based approach to food and nutrition, grounded in substantive equality and centred on historically marginalized individuals and communities. The Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Tlaleng Mofokeng, examines State obligations related to food and nutrition as deriving from the right to health and health-related rights, identifying challenges, opportunities and good practices among countries and communities across the world.

¹ See <http://public.wartburg.edu/mpsurc/images/wente.pdf>.

² Andrea D’Sylva and Brenda Beagan, “‘Food is culture, but it’s also power’: the role of food in ethnic and gender identity construction among Goan Canadian women”, *Journal of Gender Studies*, vol. 20, No. 3 (2011), p. 280.

³ Carole Counihan and Penny Van Esterik, “Introduction”, in *Food and Culture: A Reader*, Carole Counihan and Penny Van Esterik, eds. (New York, Routledge, 1997), pp. 1–7.

⁴ *Ibid.*, p. 3.

⁵ See www.fao.org/hunger/en.

⁶ See www.un.org/sustainabledevelopment/hunger.

⁷ See www.who.int/publications/i/item/9789240057661, p. 8.

⁸ See www.who.int/news-room/fact-sheets/detail/malnutrition.

⁹ See www.un.org/sites/un2.un.org/files/sg_policy_brief_extractives.pdf.

II. Methodology

6. Building off the work of previous reports (A/HRC/48/28 and A/77/197), the Special Rapporteur has chosen to focus the present report, rooted in international human rights law and standards and supported by relevant literature and the submissions received from different stakeholders and experts, on food, nutrition and the right to health. In preparing the report, she issued a call for inputs,¹⁰ inviting stakeholders to share their lived experiences and knowledge of relevant laws, policies and practices, which she aimed to reflect in the report, with a particular focus on the individuals and communities that have been made most vulnerable. The Special Rapporteur expresses her appreciation to all who contributed.¹¹

7. Prior to the issuance of the report, the mandate holder issued joint communications concerning the right to health and health-related rights, notably regarding persons living in vulnerable situations. For instance, the communications addressed food and water shortages among prisoners in Malawi and supported front-of-package nutrition warning labels in Mexico as appropriate and efficient responses to the ongoing non-communicable diseases crisis.¹²

III. Legal framework

8. The right to adequate food is a stand-alone human right.¹³ Access to food and nutrition is crucial for the enjoyment of human rights such as the rights to life, health, adequate food, non-discrimination and equality (see E/C.12/2000/4, para. 3). It is essential in improving health outcomes and reducing disparities between countries. The right to health includes access to safe food, nutrition and clean water (ibid., para. 11). States must take action to support children's healthy development, improve hygiene, ensure sufficient food and nutrition, discourage harmful behaviours and prioritize disease prevention and treatment. Emphasizing behaviour-related health issues and promoting social determinants of good health are also important actions for States to consider (ibid., para. 16).¹⁴

9. Access to safe and nutritious food is an integral part of the right to adequate food.¹⁵ The Committee on Economic, Social and Cultural Rights highlights the significance of adequacy and sustainability in relation to the right to food (see E/C.12/1999/5, para. 7). This includes the availability of food in a sufficient quantity and quality to satisfy the dietary needs of individuals that is free from adverse substances and acceptable within a given culture (ibid., para. 8). This right also implies the accessibility of food in sustainable ways that do not interfere with the enjoyment of other human rights" (ibid.). The Committee defines dietary needs to mean that diets must have a mix of nutrients supporting physical and mental growth and development, and highlights the need for measures to maintain, adapt or strengthen appropriate consumption and feeding patterns, including breastfeeding

¹⁰ See www.ohchr.org/en/calls-for-input/2023/call-inputs-food-nutrition-and-right-health.

¹¹ The Special Rapporteur also wishes to thank the researchers on the topic.

¹² See <https://spcommreports.ohchr.org/TMResultsBase/DownloadPublicCommunicationFile?gId=27699>.

¹³ Universal Declaration of Human rights, art. 25; and International Covenant on Economic, Social and Cultural Rights, art. 11.

¹⁴ See also International Covenant on Economic, Social and Cultural Rights, art. 12.

¹⁵ Universal Declaration of Human Rights, art. 25; International Covenant on Economic, Social and Cultural Rights, art. 11; Convention on the Elimination of All Forms of Discrimination against Women, art. 12 (2); Convention on the Rights of the Child, arts. 24 (2) (c) (e) and 27 (3); and Convention on the Rights of Persons with Disabilities, arts. 25 (f) and 28 (1).

(*ibid.*, para. 9). Food and nutrition are tied to a number of health-related rights, and sometimes their full realization depends on access to adequate food.

10. The Special Rapporteur acknowledges various initiatives of the international community on food and nutrition in recent years. For instance, the United Nations has declared the period 2016–2025 a Decade of Action on Nutrition. The 2030 Agenda for Sustainable Development aims to end hunger and malnutrition and promote sustainable food systems. The Special Rapporteur also stresses the World Health Organization (WHO) global action plan for the prevention and control of non-communicable diseases (2013–2020), which was extended to 2030 by the World Health Assembly, the Comprehensive Implementation Plan on Maternal, Infant, and Young Child Nutrition (2012) and the International Code of Marketing of Breast-milk Substitutes.

11. Within the context of food and nutrition, the obligation to respect human rights requires that States not engage in any conduct that is likely to result in preventable, diet-related morbidity or mortality, such as incentivizing the consumption of unhealthy foods and beverages (see [E/C.12/2000/4](#), paras. 34 and 50; and [A/HRC/26/31](#)).¹⁶

12. The obligation to protect requires States to take measures that prevent third parties, including corporations, from interfering with the enjoyment of human rights (see [E/C.12/2000/4](#), para. 33). The “failure to regulate the activities of the food and beverage industry to prevent them from violating the right to health of others and protect consumers from practices detrimental to their health may amount to a violation of the right to health” (*ibid.*, para. 51).¹⁷ States should clearly indicate the expectation that all business enterprises domiciled in their territory or jurisdiction should respect human rights throughout their operations.¹⁸ All business enterprises, regardless of their size, sector, location, ownership and structure, should refrain from infringing on human rights and should address the adverse human rights impacts to which they contributed.¹⁹

13. According to the obligation to fulfil, States must give “sufficient recognition” to the right to health, preferably through domestic legislation, and ensure “equal access for all to the underlying determinants of health, such as nutritiously safe food” (*ibid.*, paras. 33 and 36). States must “[support] people in making informed choices about their health” (*ibid.*, para. 31)²⁰ and “proactively engage in activities intended to strengthen people’s access to and utilisation of resources and means to ensure their livelihood, including food security”.²¹ States must also directly fulfil the rights to health and food when individuals and communities are unable to do so for reasons beyond their control (*ibid.*, para. 37; and [E/C.12/1999/5](#), para. 15). This may involve providing direct assistance through food vouchers or other mechanisms to persons living in vulnerable situations (see [E/C.12/1999/5](#), para. 15).²²

¹⁶ See also www.ohchr.org/en/statements/2020/07/statement-un-special-rapporteur-right-health-adoption-front-package-warning.

¹⁷ See also www.ohchr.org/en/statements/2020/07/statement-un-special-rapporteur-right-health-adoption-front-package-warning.

¹⁸ Guiding Principles on Business and Human Rights: Implementing the United Nations “Protect, Respect and Remedy” Framework.

¹⁹ *Ibid.*

²⁰ See also www.ohchr.org/en/statements/2020/07/statement-un-special-rapporteur-right-health-adoption-front-package-warning.

²¹ Committee on Economic, Social and Cultural Rights, general comment No. 12, para. 15; see also [E.C/12/2000/4](#), para. 37.

²² See also www.ohchr.org/en/publications/fact-sheets/fact-sheet-no-34-right-adequate-food#:~:text=Food%20security&text=This%20jointly%20issued%20Fact%20Sheet,of%20violations%20of%20such%20right, p. 18.

14. The International Covenant on Economic, Social and Cultural Rights prohibits any discrimination (see E/1991/23, para. 1; E/C.12/2000/4, para. 11; and E/C.12/1999/5, para. 18), including pertaining to the underlying determinants of health and specifically to access to food, and to means and entitlements for its procurement (see E/C.12/1999/5, para. 18), on various grounds, including race, ethnicity, colour, sex, language, age, religion, political or other opinion, national or social origin, property, birth, physical or mental disability and health status (including HIV/AIDS) (see E/C.12/2000/4, para. 18; and E/C.12/1999/5, para. 18). States hold some minimum core obligations that are of immediate effect, including the obligation to take deliberate, concrete and targeted steps towards realizing the right to health (see E/1991/23; and E/C.12/2000/4) and the right to food (see E/C.12/1999/5), and using “the maximum of [their] available resources” (see E/1991/23, para. 10). Under the right to health, States’ core obligations include ensuring “access to the minimum essential food which is nutritionally adequate and safe, to ensure freedom from hunger to everyone” (see E/C.12/2000/4, para. 43 (b)).

15. Furthermore, States must protect and promote exclusive breastfeeding for infants up to six months of age (see CRC/C/GC/15, para. 44);²³ address obesity in children by limiting their exposure to fast foods that are energy-dense, micronutrient-poor and high in fat, sugar or sodium; regulate the marketing of such products, especially when focused on children (ibid., para. 47); and ensure that business enterprises identify, prevent and mitigate their negative impact on children’s right to health, including across their business relationships and within any global operations (ibid., para. 80). The Convention on the Elimination of All Forms of Discrimination against Women obliges States to ensure to women “adequate nutrition during pregnancy and lactation”,²⁴ and the Convention on the Rights of Persons with Disabilities requires States to prevent discriminatory denial of food and fluids on the basis of disability.²⁵

IV. Food, nutrition and substantive equality in health

16. Systemic inequities must be addressed to tackle malnutrition and related health issues. Social determinants of health, such as socioeconomic status, race and gender, shape health outcomes and disparities.²⁶ The most vulnerable might experience poverty, have access to fewer opportunities in employment and education and have less autonomy concerning their diets and health. In turn, those with greater control over their diets and health might have more opportunities to secure their own livelihoods.²⁷ Food insecurity and other hardships also cause stress, which can promote unhealthy coping mechanisms such as substance abuse and the overconsumption of unhealthy foods and beverages.²⁸ Recognizing the intersection of social determinants of health and other frameworks exposes the systemic inequities surrounding malnutrition and its consequences.

17. The political determinants of health²⁹ drive particular outcomes around the world. For instance, the liberalization of trade policies has played a key role in increasing the free flow of unhealthy foods and beverages between countries. Through

²³ See also Convention on the Rights of the Child, art. 24.

²⁴ Convention on the Elimination of All Forms of Discrimination against Women, art. 12 (2).

²⁵ Convention on the Rights of Persons with Disabilities, art. 25 (f).

²⁶ See www.who.int/health-topics/social-determinants-of-health#tab=tab_1.

²⁷ Ibid.

²⁸ Ali Pourmotabbed and others, “Food insecurity and mental health: a systematic review and meta-analysis”, *Public Health Nutrition*, vol. 23, No. 10 (2020), pp. 1778–1790.

²⁹ Daniel Dawes, “Health inequities: a look at the political determinants of health during the COVID-19 pandemic”, *American Journal of Health Studies*, vol. 35, No. 2 (2000).

foreign direct investments, multinational corporations have purchased and invested in food-processing companies in lower-income countries to sell their products on domestic markets while avoiding tariffs and transportation costs (see [A/HRC/26/31](#)). Food, particularly the distribution of food aid and agricultural inputs, has also been used as a political tool (see [E/CN.4/2006/44/Add.2](#), para. 5; and [A/HRC/43/44/Add.2](#), paras. 103–105).

18. The commercial determinants of health, or “the private sector activities that affect people’s health, directly or indirectly, positively or negatively”,³⁰ also drive health outcomes across the world. In addition to their role in the aforementioned food production trends, multinational food and beverage corporations have steadily increased their sales and presence in lower-income countries.³¹ Corporate marketing strategies for unhealthy foods and beverages specifically target lower-income countries, while often pushing healthier products in richer countries.³² More alarming is the disproportionate targeting of groups already living in vulnerable situations, including children.³³

19. Despite the prohibition on advertising and other forms of breast-milk substitutes,³⁴ some of these industry tactics include marketing practices that employ the use of false health and nutrition claims, the cross-promotion of milks and associated brands for infants, toddlers, older children and adults, as well as lobbying and the use of trade associations and front groups.³⁵

20. The social, political, and commercial determinants of health can influence dietary patterns and reinforce nutritional and health disparities. They have driven the availability and accessibility of unhealthy foods and beverages, particularly those undergoing high levels of processing, on the global market. Since the 1980s, traditional food systems in Africa, Asia, Latin America, the Caribbean and small island developing States such as those in the Pacific have been displaced by these products, marketed largely by transnational companies.³⁶ They are associated with adverse human and planetary health outcomes,³⁷ and their manufacturing procedures involve unsustainable environmental practices that promote the exploitation of natural resources, encourage monoculture and pesticide use and contribute to climate change and social inequities.³⁸

³⁰ See www.who.int/news-room/fact-sheets/detail/commercial-determinants-of-health.

³¹ Rob Moodie and others, “Ultra-processed profits: the political economy of countering the global spread of ultra-processed foods – a synthesis review on the market and political practices of transnational food corporations and strategic public health responses”, *International Journal of Health Policy and Management*, vol. 10, No. 12 (2021), pp. 968–982.

³² Marie Bragg and others, “Comparison of online marketing techniques on food and beverage companies’ websites in six countries”, *Globalization and Health*, vol. 13, No. 1 (2017).

³³ Jennifer Harris and others, “A qualitative assessment of US Black and Latino adolescents’ attitudes about targeted marketing of unhealthy food and beverages”, *Journal of Children and Media*, vol. 13, No. 3 (2019), pp. 295–316.

³⁴ International Code of Marketing of Breast-milk Substitutes, art. 5.

³⁵ See www.thelancet.com/action/showPdf?pii=S0140-6736%2823%2900118-6.

³⁶ Julia Anaf, Fran Baum and Matt Fisher, “Global health and equity burden of commercial determinants of health”, in *The Commercial Determinants of Health*, Nason Maani, Mark Petticrew and Sandro Galea, eds., (New York, Oxford Academic, 2022); Barry Popkin and Thomas Reardon, “Obesity and the food system transformation in Latin America”, *Obesity Reviews*, vol. 19, No. 8 (2018); and Abrania Marrero and Josiemer Mattei, “Reclaiming traditional, plant-based, climate-resilient food systems in small islands”, *Lancet Planetary Health*, vol. 6, No. 2 (2022), pp. e171–e179.

³⁷ Fernanda Leite and others, “Ultra-processed foods should be central to global food systems dialogue and action on biodiversity”, *BMJ Global Health*, vol. 7, art. e008269.

³⁸ Jacqueline Da Silva and others, “Greenhouse gas emissions, water footprint, and ecological footprint of food purchases according to their degree of processing in Brazilian metropolitan areas: a time-series study from 1987 to 2018”, *The Lancet Planetary Health*, vol. 5, No. 11 (2021), pp. e775–e785.

21. Legal frameworks play a crucial role in shaping the regulatory environments that underpin the ability of communities and individuals to have equal opportunities for food and nutrition, as well as in achieving substantive equality in the realization of the right to health and health-related rights at the national, regional and global levels. It can either contribute to the realization of these rights or hinder it by perpetuating existing discriminatory norms and practices that contribute to inequalities.³⁹ Yet where strategies are lacking or fail to take systemic inequalities into account, the result is what activists have called “food apartheid”,⁴⁰ or unequal and unjust conditions for food and nutrition, which can drive certain individuals and communities to rely on increasingly ubiquitous unhealthy foods and beverages to fulfil their basic needs.

V. Food systems and food environments as drivers of health

22. Food systems encompass the entire range of actors, institutions and activities involved in the production, aggregation, processing, distribution, consumption and disposal of food.⁴¹ Every aspect of the food system shapes the food environments in which individuals and communities ultimately find themselves, determining whether diverse and nutritious food is available, accessible and acceptable to them.⁴²

23. Globalization has increased the complexity of food systems from farm to fork, with impacts on nutrition and health. Trends towards industrial-scale monocultural food production have enabled a handful of crops (e.g. palm oil, sugar cane, maize, rice and wheat) to account for over half of all global crop production, deprioritizing crops with greater nutritional value and greater economic importance for small-scale farmers.⁴³ As more resources are dedicated to industrial-scale monoculture and commodity crops,⁴⁴ some countries are becoming increasingly reliant on imports for healthy foods.⁴⁵

24. As food chains grow longer, food storage and distribution become more challenging, particularly in low-resource settings, at times affecting the quality, safety and cost of perishable foods such as fruits, vegetables, meat, fish, eggs and dairy products.⁴⁶ Simultaneously, food processing has emerged as a dominant practice and, though it extends food shelf life, it has also raised serious health concerns, particularly for ultraprocessed products.⁴⁷ Researchers have brought increased understanding to the addictive nature of ultraprocessed products.⁴⁸

25. Processes used to manufacture ultraprocessed products include the addition of low-cost ingredients such as varieties of sugars, modified oils, sources of protein and additives that are rarely or never used in typical culinary practices and are designed

³⁹ Lawrence Gostin and others, “The legal determinants of health: harnessing the power of law for global health and sustainable development”, *The Lancet*, vol. 383, No. 10183 (2019), pp. 1859–1910.

⁴⁰ See www.theguardian.com/environment/2021/may/25/karen-washington-garden-of-happiness-us-food-system.

⁴¹ See www.unicef.org/reports/state-of-food-security-and-nutrition-2020.

⁴² See www.fao.org/3/i7846e/i7846e.pdf.

⁴³ See www.unicef.org/reports/state-of-food-security-and-nutrition-2020.

⁴⁴ See www.unep.org/news-and-stories/story/10-things-you-should-know-about-industrial-farming.

⁴⁵ See www.fao.org/3/cc0639en/cc0639en.pdf.

⁴⁶ See www.fao.org/3/cb1329en/cb1329en.pdf.

⁴⁷ See www.fao.org/3/ca5644en/ca5644en.pdf.

⁴⁸ Ashley Gearhardt and Johannes Hebebrand, “The concept of ‘food addiction’ helps inform the understanding of overeating and obesity: YES”, *The American Journal of Clinical Nutrition*, vol. 113, No. 2 (2021), pp. 263–267; and Barry Popkin and Shu Wen Ng, “The nutrition transition to a stage of high obesity and noncommunicable disease prevalence dominated by ultra-processed foods is not inevitable”, *Obesity Reviews*, vol. 23, No. 1 (2022), art. e13366.

to give products intense sensory properties (i.e. attractive to see, taste, smell or touch) that make them highly palatable and profitable.⁴⁹

26. Food enters retail markets, shaping the environments in which individuals make decisions about purchasing, preparing and consuming food. Corporations have stimulated an increasing demand for ultraprocessed products through advertising, promotions and other marketing strategies that disproportionately target children, racial and ethnic minorities and people from socially disadvantaged backgrounds.⁵⁰ For example, between 2000 and 2013, the consumption of ultraprocessed products in Latin America increased by more than 25 per cent, and fast food consumption by 40 per cent.⁵¹ Similar trends were seen in parts of Africa as well.⁵²

27. The exponential growth of supermarkets and fast food chains is displacing smaller, informal, fresh food markets that sell locally sourced food. Between 1990 and 2000, supermarkets' share of all retail food sales in Latin America increased from 15 per cent to 60 per cent, with similar transitions occurring in Asia, parts of Europe, the Middle East and urban parts of Africa.⁵³ This shift in food environments favours larger-scale suppliers, often multinationals, that can meet supermarkets' needs and requirements over smaller-scale ones – reinforcing power imbalances throughout the food system.

28. Certain disadvantaged communities are experiencing a shift from traditional, healthier diets to those increasingly consisting of unhealthy food and beverage products, often ultraprocessed,⁵⁴ while still facing high rates of hunger and food insecurity. To some extent, this nutrition transition has replicated colonial power structures and relations, with traditional diets and food cultures being supplanted by diets largely shaped by corporations headquartered in historically powerful and wealthy countries.⁵⁵

29. Malnutrition manifests itself in various forms, including undernutrition, overweight, obesity and diet-related non-communicable diseases. Around 45 per cent of deaths among children under 5 years are related to undernutrition, largely in low- and middle-income countries. In 2020, an estimated 149 million children under 5 years were stunted (too short for their age), and 45 million were wasted (too thin for their height).⁵⁶ Micronutrient deficiencies also remain a major global problem, particularly for children, pregnant persons and other groups with higher nutrient requirements.⁵⁷

30. The increased consumption of unhealthy foods and beverages, with excess sugar, sodium or fats and often ultraprocessed, is associated with the primary cause of death globally, namely rising rates of non-communicable diseases, which

⁴⁹ See www.fao.org/3/ca5644en/ca5644en.pdf.

⁵⁰ Barry Popkin and Shu Wen Ng, “The nutrition transition to a stage of high obesity and noncommunicable disease prevalence dominated by ultra-processed foods is not inevitable”.

⁵¹ See https://iris.paho.org/bitstream/handle/10665.2/7699/9789275118641_eng.pdf.

⁵² See www.sciencedirect.com/science/article/pii/S2211912420301206.

⁵³ Barry Popkin and others, “Global nutrition transition and the pandemic of obesity in developing countries”, *Nutrition Reviews*, vol. 70, No. 1 (2012), pp. 3–21.

⁵⁴ Barry Popkin and Shu Wen Ng, “The nutrition transition to a stage of high obesity and noncommunicable disease prevalence dominated by ultra-processed foods is not inevitable”.

⁵⁵ Permani Weerasekara and others, “Nutrition transition and traditional food cultural changes in Sri Lanka during colonization and post-colonization”, *Foods*, vol. 7, No. 7 (2018), p. 111.

⁵⁶ See www.who.int/news-room/fact-sheets/detail/malnutrition.

⁵⁷ See www.who.int/publications/m/item/WHO-WFP-UNICEF-statement-micronutrients-deficiencies-emergency.

ultimately lead to higher rates of illness and death.⁵⁸ Once considered a problem of higher-income countries, overnutrition is now linked to more deaths than undernutrition in nearly all parts of the world.⁵⁹

31. Global food production has increased by 300 per cent since the mid-1960s, yet this growth largely reflects the increased production of processed and ultraprocessed products associated with non-communicable diseases.⁶⁰ What results is a double burden of malnutrition whereby both undernutrition and overnutrition exist within countries, communities and families and even within single individuals over a life course.⁶¹ This double burden of malnutrition is highly prevalent in over a third of low- and middle-income countries, slowing progress in addressing malnutrition and impeding economic development.⁶² At the individual level, complex biological factors come into play when an individual is exposed to undernutrition prenatally or in early childhood⁶³ and is later exposed to unhealthy diets, resulting in sharp increases in childhood and adult obesity.⁶⁴

VI. Food, nutrition and infectious diseases

A. The cycle of infection and malnutrition

32. The enjoyment of the right to health is affected by a synergistic relationship between food, nutrition and infectious diseases. Malnutrition is one of the main causes of immunodeficiency and makes individuals more susceptible to infection, which in turn can contribute to malnutrition, resulting in a vicious cycle of poor health (see [A/71/282](#)).⁶⁵ The coronavirus disease (COVID-19) increased the world's understanding of how malnutrition, including both undernutrition on the one hand and overweight, obesity and diet-related non-communicable diseases on the other hand, can increase the severity of an infectious disease,⁶⁶ and how pandemics in turn can increase the burden of malnutrition.⁶⁷

33. Malnutrition alters the body's immune responses, which can protect against viral proliferation, especially in infants, children, adolescents and older adult populations.⁶⁸ Two billion people suffer from micronutrient deficiencies, including vitamins A, C and E and the minerals zinc, iron and iodine, which impair the body's

⁵⁸ Global Burden of Metabolic Risk Factors for Chronic Diseases Collaboration, "Cardiovascular disease, chronic kidney disease, and diabetes mortality burden of cardiometabolic risk factors from 1980 to 2010: a comparative risk assessment", *The Lancet Diabetes and Endocrinology*, vol. 2, No. 8 (2014), pp. 634–647.

⁵⁹ See www.who.int/news-room/fact-sheets/detail/obesity-and-overweight.

⁶⁰ See www.un.org/sg/en/content/sg/statement/2021-07-12/statement-the-secretary-general-the-food-systems-summit.

⁶¹ See www.who.int/publications/i/item/WHO-NMH-NHD-17.3.

⁶² Paraskevi Seferidi and others, "Global inequalities in the double burden of malnutrition and associations with globalisation: a multilevel analysis of Demographic and Health Surveys from 55 low-income and middle-income countries, 1992–2018", *The Lancet Global Health*, vol. 10, No. 4 (2022), pp. e482–e490.

⁶³ See www.unicef.org/reports/undernourished-overlooked-nutrition-crisis.

⁶⁴ See www.who.int/news-room/fact-sheets/detail/obesity-and-overweight.

⁶⁵ See also www.who.int/news-room/fact-sheets/detail/malnutrition.

⁶⁶ See www.fao.org/3/ng808en/ng808en.pdf, p. 13.

⁶⁷ Sudipta Hyder and others, "Pestilence and famine: continuing down the vicious cycle with COVID-19", *PLOS Pathogens*, vol. 18, No. 10 (2022), p. e1010810.

⁶⁸ Ashmika Foolchand and others, "Malnutrition and dietary habits alter the immune system which may consequently influence SARS-CoV-2 virulence: a review", *International Journal of Molecular Sciences*, vol. 23, No. 5 (2022), p. 2654.

ability to form antibodies and develop a strong immune system.⁶⁹ Nutritional deficiencies during pregnancy are associated with poor immune responses to infection in infants. Breastfeeding is recognized as providing “optimal nutrition”, capable of reducing infectious diseases among infants (ibid.).⁷⁰ Malnourished children are more likely to die from common childhood infections such as pneumonia, malaria, measles and diarrhoea.⁷¹

34. Infection in turn can aggravate a person’s nutritional status owing to diarrhoea, loss of appetite, malabsorption of nutrients and diversion of nutrients to the immune response, exacerbating malnutrition.⁷² For example, intestinal parasitic infections, which affect 3.5 billion people and kill 200,000 mostly school-aged children every year, can both lead to malnutrition and be worsened by coexistent malnutrition or micronutrient deficiencies.⁷³

35. Furthermore, a nutritious diet can help people living with HIV, tuberculosis or malaria, for example, to manage symptoms and maximize the benefits of medication, optimizing health and survival and enhancing quality of life.⁷⁴ It is thus critical that health systems incorporate nutritional services into infectious disease treatment programmes.

B. Food safety

36. Food can also become contaminated by infectious or otherwise toxic agents (e.g. bacteria, viruses, parasites and chemicals) during processing and handling, particularly where regulatory oversight is lacking.⁷⁵ About 600 million people, or 1 in 10 individuals, become ill from eating contaminated food annually, resulting in the loss of 420,000 lives and 33 million disability-adjusted life years.⁷⁶ In 2019, the World Bank estimated the total productivity loss associated with foodborne disease to be \$95.2 billion per year and the annual cost of treating foodborne illnesses to be \$15 billion.⁷⁷

37. Yet from a policy standpoint, food safety and nutrition are rarely integrated, with policies intended to address either safety or nutrition, but not both.⁷⁸ At all levels of governance, such policies must be understood as mutually reinforcing, echoing a rights-based approach that includes both food safety and nutrition considerations.

VII. Food, nutrition and non-communicable diseases

38. The increased consumption of ultraprocessed foods, often laden with sugar, sodium or fats, can cause raised blood pressure, increased blood glucose and obesity,

⁶⁹ Peter Katona and Judit Katona-Apte, “The interaction between nutrition and infection”, *Clinical Infectious Diseases*, vol. 46, No. 10 (2008), pp. 1582–1588.

⁷⁰ See also www.thelancet.com/action/showPdf?pii=S0140-6736%2823%2900118-6.

⁷¹ See www.who.int/news-room/fact-sheets/detail/levels-and-trends-in-child-under-5-mortality-in-2020#:~:text=Globally%2C%20infectious%20diseases%2C%20including%20pneumonia,for%20children%20under%205%20years.

⁷² See www.ncbi.nlm.nih.gov/books/NBK304206.

⁷³ Sunil Tulshiram Hajare and others, “Prevalence of intestinal parasite infections and their associated factors among food handlers working in selected catering establishments from Bule Hora, Ethiopia”, *BioMed Research International*, vol. 2021, art. 6669742 (2021).

⁷⁴ See www.fao.org/3/y4168E/y4168e04.htm.

⁷⁵ See www.who.int/news-room/fact-sheets/detail/food-safety.

⁷⁶ Ibid.

⁷⁷ See <http://hdl.handle.net/10986/30568>.

⁷⁸ See www.sciencedirect.com/science/article/pii/S2211912421001012.

of which all are metabolic risk factors for cardiovascular disease.⁷⁹ Diets high in sodium and low in whole grains, vegetables and fruits contribute to approximately half of all mortalities and two thirds of diet-related disability-adjusted life years.⁸⁰ In 2019, for example, approximately 1.8 million non-communicable disease-related deaths were attributed to excess sodium intake.⁸¹

39. Non-communicable diseases place enormous human rights challenges on individuals and families, from financial hardships due to treatment and care costs to lost productivity that threatens household income.⁸² Furthermore, rising rates of non-communicable diseases threaten economic development at the State level, requiring Governments to contribute large portions of health-care spending to their treatment.⁸³ Maternal and child health are also inextricably linked with non-communicable diseases, as prenatal malnutrition is associated with stillbirths, preterm births and gestational diabetes and is further associated with the offspring's vulnerability to cardiovascular disease and diabetes (see [A/66/83](#), para. 31). Non-communicable diseases can also interfere with the effective treatment and control of other health issues such as HIV and tuberculosis.⁸⁴

40. The Special Rapporteur echoes the Committee for the Elimination of Racial Discrimination in considering that there has not been sufficient attention in the public health arena as to how non-communicable diseases are related to racial discrimination alone.⁸⁵ A gendered perspective is also critical for understanding the impacts of non-communicable diseases, as gender roles and social marginalization can affect the risk of such diseases, the feasibility of behaviour modification strategies and the success of interventions.⁸⁶ Given that most studies on non-communicable diseases have focused on men, women may be less likely to be diagnosed with such a disease at an early stage.⁸⁷ Furthermore, women are often the sole caretakers for persons with non-communicable diseases, a typically unpaid role that can require their departure from the workforce and drive their impoverishment.⁸⁸ Additionally, as grounds for discrimination often intersect, such as with race, ethnicity, national origin, gender, age, disability, migratory status, class, social status or income, an individual can experience multiple yet inseparable barriers to health and nutrition and face heightened risks for diet-related non-communicable diseases.⁸⁹

41. Given that non-communicable diseases lead to preventable morbidity and mortality with tangible human rights implications, international human rights law mandates that States address non-communicable disease risk factors, including unhealthy diets. States' failure to do so may amount to violations of the right to health and health-related rights (see [A/HRC/26/31](#)).

⁷⁹ See www.who.int/news-room/fact-sheets/detail/noncommunicable-diseases.

⁸⁰ Global Diet Collaborators, "Health effects of dietary risks in 195 countries, 1990–2017: a systematic analysis for the Global Burden of Disease Study 2017", *The Lancet*, vol. 393, No. 10184 (2019), pp. 1958–1972.

⁸¹ See www.who.int/news-room/fact-sheets/detail/noncommunicable-diseases.

⁸² See www.who.int/publications/i/item/9789240057661, p. 17.

⁸³ *Ibid.*

⁸⁴ See www.who.int/publications/i/item/9789240057661, p. 12.

⁸⁵ See www.ohchr.org/en/documents/general-comments-and-recommendations/first-draft-general-recommendation-no-37-2023-racial, para. 11.

⁸⁶ See www.paho.org/hq/dmdocuments/2012/PAHO-Factsheet-Gender-English.pdf.

⁸⁷ *Ibid.*

⁸⁸ *Ibid.*

⁸⁹ See www.ohchr.org/sites/default/files/documents/issues/minorities/30th-anniversary/2022-09-22/GuidanceNoteonIntersectionality.pdf.

A. Food and nutrition in clinical settings

42. People are not inherently vulnerable.⁹⁰ there are racial and socioeconomic health disparities that appear neutral yet disproportionately harm individuals on multiple axes of oppression. Understood as food oppression theory, these are institutional, systemic, food-related actions or policy that physically debilitate a socially marginalized group, the effects of which lead to food vacuums, which also increase the groups' vulnerability by constraining their political voices, reducing their work capacity and draining the energy of household and community members who must care for the sick and take on the responsibilities that ill members cannot fulfil. Food oppression diminishes populations already in vulnerable situations in numbers and in power. Illness arising from food oppression also leads to social invisibility, decreased social status, depression and despair;⁹¹ active tuberculosis affects people who are malnourished; and cancer treatment, HIV and diabetic care require access to nutritious and adequate food. The food vacuum means that patients who cannot afford three meals a day or a snack with which to take their medication risk being labelled non-adherent in health-care settings.

43. The Special Rapporteur, within the context of health, identified individuals and communities living in vulnerable situations as “including people living in poverty; women; Indigenous Peoples; persons with disabilities; older persons; minorities; internally displaced persons; persons in overcrowded settings and in residential institutions; people in detention; homeless persons; migrants and refugees; people who use drugs; and lesbian, gay, bisexual, transgender and gender-diverse persons” (see [A/HRC/47/28](#), para. 103). Many of these individuals and communities are also neglected in today's food and health systems, where “power asymmetries also dominate ... within and among countries” (see [A/77/197](#)). An intersectional lens is thus critical to understanding and addressing the compounding impacts of food systems on individuals and communities placed in vulnerable and oppressive situations.

44. Screening for food insecurity among patients helps health professionals to improve patient care and develop approaches to support patients in managing their conditions well. Screening for food insecurity in health-care settings is highly accepted among patients. Approximately 84 per cent of patients reported high levels of acceptability about food insecurity screening and stated that it was valuable in the primary care setting.⁹²

45. Older adults experiencing food insecurity are more likely to have multiple chronic conditions, including asthma, chronic bronchitis or chronic obstructive pulmonary disease, chronic pain, diabetes, kidney disease and sleep disorders, than food-secure counterparts,⁹³ and older women have an increased risk of osteoporosis. Food insecurity has been associated with delaying medical care, the timely and adequate intake of medications and higher levels of service use such as emergency department visits and hospitalizations.

⁹⁰ See <https://genevasolutions.news/global-health/dr-tlaleng-mofokeng-promoting-the-right-to-health-in-the-wake-of-covid-19>. The Special Rapporteur also gave a speech on food governance in 2021, see www.sydney.edu.au/charles-perkins-centre/news-and-events/news/2021/12/10/global-health-leaders-to-address-drivers-of-unhealthy-food-systems.html.

⁹¹ Andrea Freeman, “The unbearable whiteness of milk: food oppression and the USDA,” *UC Irvine Law Review*, vol. 3 (2013), p. 1251.

⁹² Anil Kopparapu and others, “Food insecurity in primary care: patient perception and preferences” *Family Medicine*, vol. 52, No. 3 (2020), pp. 202–205.

⁹³ Yangbo Sun and others, “Food insecurity is associated with cardiovascular and all-cause mortality among adults in the United States”, *Journal of the American Heart Association*, vol. 9, No. 19 (2020), art. e014629.

46. Studies have demonstrated that the consumption of dietary antioxidants, such as carotenes, ascorbic acid and vitamin D, might offer a protective role against inflammation⁹⁴ and multifactorial disorders affecting uterine and ovarian health in people of reproductive age, which are often characterized by ovulatory dysfunction, altered menstruation, ovarian cysts and endometriosis, among other things.
47. Poor access to management of abnormal menstrual bleeding and menstruation-related disorders such as fibroids and endometriosis can lead in the long term to iron deficiency and later anaemia, which can cause lethargy, headaches, dizziness, craving for ice or clay and irregular heartbeat,⁹⁵ directly affecting the overall quality of life.
48. Enforced exclusion from public life resulting from the perception that menstruation is dirty may include prohibitions such as handling food or entering religious spaces or the requirement that women and girls isolate themselves. This leads to self-imposed isolation due to years of social conditioning and shame projected onto them,⁹⁶ affecting mental and physical health.
49. Suboptimal diets leading to folic acid, vitamin D and iron deficiencies and higher maternal weight during preconception and pregnancy can increase the risk of pregnancy complications and non-communicable diseases in pregnant persons and their children.⁹⁷ In crisis situations, the United Nations Population Fund often provides iron folate, vitamin A and other supplements to ensure good nutrition for lactating mothers and their babies.
50. The right to non-discrimination requires health-care workers to pay special attention to clinical practices, stigmas and the lack of education on how to support the need for food security and nutrition across the life cycle. This is in line with entitlements that include the right to a system of health protection (i.e. health care and the underlying social determinants of health), which provides equality of opportunity for people to enjoy the highest attainable standard of health.
51. Health-care settings and facilities must operate with other social systems and connect patients with programmes and resources that promote access to food, food banks and financial assistance as a mechanism to aid patients in reducing competing needs between food and medications.
52. Health professionals need to understand the relationship between food insecurity and poor health outcomes and the challenges experienced by food-insecure individuals. This helps health professionals to become more sensitive to patients' needs and adapt treatment and services accordingly, in order to improve the control and management of health conditions of patients. This relationship between food and health was recognized in the ancient practice of medicine and is still just as true and relevant in modern medicine.⁹⁸

⁹⁴ Michał Ciebiera and others, "Nutrition in gynecological diseases: current perspectives, *Nutrients*, vol. 13, No. 4 (2021), p. 1178.

⁹⁵ See www.hematology.org/education/patients/anemia/iron-deficiency.

⁹⁶ See www.unfpa.org/menstruationfaq.

⁹⁷ Fionnuala McAuliffe and others, "Management of prepregnancy, pregnancy, and postpartum obesity from the FIGO Pregnancy and Non-Communicable Diseases Committee: a FIGO (International Federation of Gynecology and Obstetrics) guideline", *International Journal of Gynecology and Obstetrics*, vol. 151, Suppl. 1 (2020), pp. 16–36.

⁹⁸ Bong Nguyen and Betty Drees, "Food and nutrition security in clinical settings", *Missouri Medicine*, vol. 119, No. 2 (2022), pp. 167–172.

VIII. Climate change, conflict and the coronavirus disease

53. Climate change is “driving hunger like never before”, largely affecting communities that contribute little themselves to CO₂ emissions.⁹⁹ Over 80 per cent of the world’s hungriest people live in climate disaster-prone countries, and nearly a quarter of the world’s farmable lands are degraded.¹⁰⁰ Climate disasters are destroying homes, land, livestock, crops and other food supplies, causing food prices to skyrocket as supplies dwindle.¹⁰¹ Aside from increased risks of undernutrition and hunger, climate change is also projected to increase the risk of foodborne and waterborne diseases, given accelerated microbial growth and the shifting distribution of diseases.¹⁰²

54. Increasing food insecurity and competition for natural resources drives instability, leading to land grabs and conflict.¹⁰³ Conflict is the top driver of hunger, contributing to 80 per cent of the world’s worst food crises.¹⁰⁴ The Food and Agriculture Organization of the United Nations has warned that people in over 20 countries are facing acute food insecurity, with ongoing violence and conflict continuing to worsen many of these situations.¹⁰⁵

55. In 2018, the Security Council called on parties to armed conflict to forgo targeting sites that produce and distribute food and using starvation as a weapon of war, and to allow humanitarian personnel to be granted safe access to civilians (see resolution 2417 (2018)). Yet parties to conflict continue to use food as a weapon of war by controlling food production, denying food to the opposition and exploiting hunger and poverty.¹⁰⁶

56. Disruptions to food systems caused by COVID-19 disproportionately affected small-scale farmers and sellers who operate in informal markets.¹⁰⁷ As travel restrictions disrupted supply chains and inflated food prices, almost 3.1 billion people could not afford a healthy diet in 2020, compared with 112 million in 2019,¹⁰⁸ driving 150 million more into hunger and 350 million more into food insecurity compared with pre-pandemic levels.¹⁰⁹

57. As of January 2021, over 39 billion school meals – the only nutritious meal of the day for many children – had been missed owing to school closures, escalating rates of childhood wasting, stunting and overweight.¹¹⁰ For older adults and immunocompromised persons, COVID-19 increased the risk of malnourishment and vulnerability to disease.¹¹¹ Marginalized groups, including LGBTQ+ persons, faced heightened challenges in access to food and food aid during the pandemic, which in many cases reflected policies that relied on binary definitions of gender or narrow conceptions of family for distributing food, workplace discrimination and social

⁹⁹ See <https://news.un.org/en/story/2021/07/1095672>.

¹⁰⁰ See www.wfpusa.org/drivers-of-hunger/climate-change.

¹⁰¹ Ibid.

¹⁰² See www.paho.org/en/topics/climate-change-and-health.

¹⁰³ See www.wfpusa.org/wp-content/uploads/2020/11/WFP-USA-Winning-the-Peace-2020.pdf.

¹⁰⁴ See www.wfpusa.org/drivers-of-hunger/#:~:text=Conflict%20is%20the%20%231%20driver,infrastructure%20and%20halts%20agricultural%20production.&text=Climate%20change%20is%20one%20of,and%20intense%20extreme%20weather%20events.

¹⁰⁵ See https://docs.wfp.org/api/documents/WFP-0000136243/download/?_ga=2.40233314.1142932074.1683040665-2146118121.1683040665.

¹⁰⁶ See www.wfpusa.org/wp-content/uploads/2020/11/WFP-USA-Winning-the-Peace-2020.pdf.

¹⁰⁷ See www.wfpusa.org/drivers-of-hunger/covid-19.

¹⁰⁸ See www.fao.org/newsroom/detail/un-report-global-hunger-SOFI-2022-FAO/en.

¹⁰⁹ Ibid.

¹¹⁰ See www.wfpusa.org/drivers-of-hunger/covid-19.

¹¹¹ See www.csis.org/analysis/new-covid-19-mantra-nobody-safe-until-everybody-fed.

exclusion practices, as well as discriminatory service provision.¹¹² Reversing the pandemic’s impact on food and nutrition is forecast to take years, if not decades.¹¹³

58. At the same time, many corporate actors in the food and beverage industry took advantage of the COVID-19 pandemic to position themselves as part of the solution to rising hunger and food insecurity, improving their image to increase their sales.¹¹⁴ Such strategies included coupling pandemic relief actions (e.g. donations) with aggressive marketing of ultraprocessed products;¹¹⁵ promoting ultraprocessed products as being safer and free of contamination; donating ultraprocessed products to individuals in vulnerable situations, such as programmes for schoolchildren or low-income populations; and highlighting philanthropic activities while actively lobbying against public health policies to address diet-related non-communicable diseases.¹¹⁶ These activities constitute a form of so-called corporate social responsibility, whereby corporate actors voluntarily engage in activities that claim to prioritize social goals (e.g. public health) over profit.¹¹⁷ Yet such activities are often a public relations exercise to create an illusion that a company is socially conscious while it continues to engage in harmful practices that can impair the enjoyment of human rights.

IX. Food systems governance for health

59. Food systems governance can be defined as “the institutions, actors, rules, and norms that shape how food is produced, distributed, and accessed across borders [and] the processes by which diverse actors within food systems are incorporated into decision and policymaking at different levels”.¹¹⁸ Food systems governance consists of “competing and overlapping networks composed of actors including States, civil society, philanthropies and transnational corporations who draw on vastly different resources in exercising power”.¹¹⁹

60. “While it is important that solutions to address disparities in food insecurity focus on combating interpersonal discrimination, the need to target structural racism [and discrimination] is critical in the fight for achieving equity in food security and improve related outcomes in people of color”,¹²⁰ as well as black people and people of African descent, Indigenous Peoples and other marginalized communities. The colonial legacies of land dispossession have seen these communities increasingly forced to live where there is air, water and land pollution and in high-density spaces.

A. Addressing conflicts of interest

61. The Special Rapporteur on the right to food stated that “multi-stakeholder governance also leaves the role of States unclear and does not address their role as

¹¹² Submission by Outright International.

¹¹³ See <https://news.un.org/en/story/2021/07/1095672>.

¹¹⁴ See https://ncdalliance.org/sites/default/files/resource_files/Signalling%20Virtue%2C%20Promoting%20Harm_Sept2020_FINALv.pdf.

¹¹⁵ See <https://coca-colafemsa.com/noticias/apoyo-a-comunidades-y-profesionales-de-la-salud-en-latinoamerica>.

¹¹⁶ See <https://dfweawn6ylvgz.cloudfront.net/uploads/2020/11/GHAI-Facing-Two-Pandemics-Report-November-2020.pdf>.

¹¹⁷ See <https://apps.who.int/iris/handle/10665/201349>.

¹¹⁸ Matthew Canfield and others, “Reconfiguring food systems governance: the UNFSS and the battle over authority and legitimacy”, *Development*, vol. 64 (2021), pp. 181–191.

¹¹⁹ Ibid.

¹²⁰ Angela Odoms-Young, “Examining the impact of structural racism on food insecurity: implications for addressing racial/ethnic disparities”, *Family and Community Health*, vol. 41, Suppl. 2 (Food Insecurity and Obesity) (2018).

the main duty bearers” (see [A/76/237](#)). Ultimately, States are obligated under international human rights law to respect, protect and fulfil human rights. Under the obligation to respect, States must refrain from directly or indirectly interfering with the enjoyment of the right to health and health-related rights (see [E/C.12/2000/4](#), para. 33) by refraining from entering into partnerships in policymaking that subordinate health, particularly the health of the most vulnerable. Moreover, by allowing legitimate decision-making processes to be co-opted by private interests that often compete with public health interests, States may become complicit to the point of violating this obligation.¹²¹ States’ obligation to protect requires them to prevent third parties, including corporations, from interfering with the enjoyment of human rights (*ibid.*, para. 33). This obligation is particularly relevant to the context of multinational food and beverage corporations and their influence over food systems governance, and requires States to establish rules of engagement (see [E/C.12/GC/25](#), para. 53; and [A/HRC/48/61](#), para. 77) and adopt measures relevant to good food systems governance.

62. It is often the case that some actors, especially corporate actors, have a vested interest in the proliferation of weak and ineffective regulatory regimes, and they may use corporate power to influence regulation.¹²²

63. The WHO draft approach for the prevention and management of conflicts of interest in policy development and the implementation of nutrition programmes at the country level, supported by the Pan American Health Organization road map for implementation, are attempts to prevent and manage conflicts of interest. They include six steps for decision-making.

64. Enhancing access to information will be beneficial to ensure greater accountability and participation in food systems governance and ultimately to safeguard the right to health. As the previous Special Rapporteur on the right to health stated, “the right to health framework [...] requires transparency in activities that directly or indirectly affect governance. It acts as a check against arbitrary decisions that may be taken by States and pre-empts violations of the right to health. [...] States could ensure transparency [and] make the content of negotiations and agreements available for public scrutiny and invite comments by stakeholders such as farmers and consumers before entering into these agreements” (see [A/HRC/26/31](#), para. 52).

B. Participation

65. “Promoting health must involve effective community action in setting priorities, making decisions, planning, implementing and evaluating strategies to achieve better health” (see [E/C.12/2000/4](#), para. 54). The meaningful and consequential participation required to realize the rights to health and health-related rights is intricately connected to States’ obligation of non-discrimination, which is of immediate effect (*ibid.*). Yet legacies of discrimination on the basis of race, ethnicity, sex, sexual orientation, age and socioeconomic and other factors continue to plague food systems governance at all levels.

66. Women’s participation in agrifood systems has been described as “constrained by discriminatory social norms and barriers to knowledge, assets, resources and social networks”.¹²³ Numerous States have also reported on the lack of opportunities for participation by Indigenous populations and migrants in designing policies to increase

¹²¹ Organization of American States document OEA/Ser.L/V/II; and Isabel Barbosa and others, “State obligations in the context of unhealthy diets: paving the way within the Inter-American human rights system, *Revista Internacional de Derechos Humanos*, vol. 11, No. 1 (2021).

¹²² African Commission on Human and Peoples’ Rights, resolution 7.

¹²³ See www.fao.org/3/cc5343en/cc5343en.pdf, p. xviii.

access to food, food production and nutrition.¹²⁴ Peasants and others working in rural areas are also critical populations when it comes to food systems governance for health, and their “right to participate in policy design, decision-making, implementation, and monitoring of any project, programme or policy affecting their land and territories” must be realized (see [A/HRC/WG.15/1/2](#)).

67. Participatory approaches such as alternative food networks, food policy councils and food sovereignty movements, which are forming “an interesting manifestation for participation in just food governance”, may help to create more just and sustainable food systems.¹²⁵ Such approaches can better align with the right to health requirement for participation by the affected population in all health-related decisions from the community to the international level (see [E/C.12/2000/4](#), para. 11).

X. Regulating food systems for health

68. The Special Rapporteur agrees that the “promotion and protection of health are inextricably linked to promotion and protection of human rights and dignity”.¹²⁶ Consequently, health and health-related regulatory measures should not be approached as presumably conflicting with human rights, but rather as mutually reinforcing frameworks.¹²⁷

69. International human rights law promotes policymaking and decision-making grounded in the best available scientific evidence (see [E/C.12/GC/25](#), para. 54), free from conflicts of interest, as explored above. Consequently, States should endeavour to align their policies with the best scientific evidence available (*ibid.*). This is relevant to the context of regulating food systems, given the growing evidentiary support for certain measures designed to address malnutrition.

A. Protecting rights to land, biodiversity and other natural resources

70. “Land is not only a resource for producing food, generating income and developing housing, it also constitutes the basis for social, cultural and religious practices and the enjoyment of the right to take part in cultural life” (see [E/C.12/GC/26](#), para. 1). Land grabbing, whereby investors acquire land for large-scale projects such as agro-industrial plantations or mining operations, triggers poverty, food insecurity and the loss of livelihoods for local communities, with harmful impacts on health.¹²⁸ Dispossessing, occupying and allowing the destruction of lands used for farming, herding, hunting, fishing and foraging eliminates the ability of Indigenous and other local communities to produce their own foods for a healthy diet, turning food into a commodity controlled by those in power.¹²⁹ It therefore violates their right to adequate food and their right to health, considering that adequate food is an underlying determinant of health (see [E/C.12/2000/4](#), para. 4), and

¹²⁴ Submissions by multiple States and organizations (e.g. Guatemala, Chile and FIAN Colombia).

¹²⁵ Suvi Huttunen and others, “Participation for just governance of food-system transition”, *Sustainability: Science, Practice and Policy*, vol. 18, No. 1 (2022), pp. 500–514.

¹²⁶ Jonathan Mann and others, “Health and human rights”, *Health and Human Rights*, vol. 1, No. 1, pp. 6–23.

¹²⁷ *Ibid.*

¹²⁸ See <https://news.un.org/en/story/2011/10/390162#:~:text=The%20practice%20of%20%E2%80%9Cland%20grabbing,Nations%20independent%20expert%20warned%20today.>

¹²⁹ The Special Rapporteur agrees with the Special Rapporteur on the right to food that when agricultural resources are turned into commodities “it becomes easier for a small number of people to control [agricultural resources] by restricting access against the majority of humanity” (see [A/HRC/49/43](#)).

threatens health for all, as Indigenous people protect 80 per cent of the Earth's biodiversity.¹³⁰

71. Biodiversity can increase where policies, along with investments in research, technology and infrastructure, are repurposed to incentivize the production of nutritious foods, including fruits, vegetables and legumes,¹³¹ and agricultural metrics measure nutrition-related aspects such as nutrient content per unit of land or labour¹³² while also increasing income for local producers, aligning with the rights to health and health-related rights frameworks.¹³³

72. Land is an essential element for the realization of many human rights.¹³⁴ The Committee on Economic, Social and Cultural Rights explicitly recognizes that land use can affect the enjoyment of the rights to adequate food and health (see [E/C.12/GC/26](#), para. 9). Furthermore, it provides that the principles of non-discrimination and substantive equality require that women, Indigenous Peoples and rural communities be given particular attention in laws and policies relating to land given their connection to the land and history of discrimination (see [E/C.12/GC/26](#), para. 12). Individuals and communities should also be provided with information and opportunities to participate in decision-making relating to land (see [E/C.12/GC/26](#), paras. 20 and 21).

B. Front-of-package nutrition labelling

73. Mandatory front-of-package nutrition labelling has been identified as a key policy tool,¹³⁵ which should allow consumers to correctly, quickly and easily identify products that contain excess sugar, sodium and fats by providing them with accurate, transparent and easily understandable nutritional information.¹³⁶

74. Under the right to health framework, mandatory front-of-package nutrition labelling, and specifically warning labels, aligns with States' obligation to protect the right to health and health-related rights by requiring that third parties – in this case, corporations – convey accurate, easily understandable and transparent information about products with excessive critical nutrients so that individuals can make informed dietary decisions (see [E/C.12/GC/24](#), para. 19).¹³⁷

75. Front-of-package nutrition labelling also contributes to the realization of the right to information and the right to benefit from scientific progress and its application,¹³⁸ which includes access to scientific knowledge and information (see [E/C.12/GC/25](#), para. 8).

¹³⁰ See www.un.org/development/desa/dspd/2021/04/indigenous-peoples-sustainability.

¹³¹ See www.cepal.org/en/publications/48532-towards-sustainable-food-and-nutrition-security-latin-america-and-caribbean.

¹³² World Bank Group, "An overview of links between obesity and food systems: implications for the food and agriculture global practice agenda", June 2017.

¹³³ See www.fao.org/3/cc3859en/cc3859en.pdf. The Commission on Economic, Social and Cultural Rights is currently drafting a general comment that will delineate State obligations relating to sustainable development, including biodiversity, as a human rights issue, see www.ohchr.org/en/treaty-bodies/cescr/general-comment-sustainable-development-and-international-covenant-economic-social-and-cultural.

¹³⁴ See www.ohchr.org/sites/default/files/Documents/Publications/Land_HR-StandardsApplications.pdf.

¹³⁵ See https://iris.paho.org/bitstream/handle/10665.2/52740/PAHONMHRF_200033_eng.pdf?sequence=6&isAllowed=y, p. 7.

¹³⁶ Ibid.

¹³⁷ See also www.ohchr.org/en/statements/2020/07/statement-un-special-rapporteur-right-health-adoption-front-package-warning.

¹³⁸ Ibid.

C. Marketing

76. Many food and beverage corporations have also engaged in marketing strategies to elevate their brand, portraying themselves as working to address social, economic, environmental and health problems through corporate washing strategies.¹³⁹ This includes greenwashing, or creating a perception that companies are altering their business practices to protect the environment, such as through altered product packaging.¹⁴⁰ Such strategies can be highly deceptive, luring consumers into believing that certain products are more sustainable, or in some cases more nutritious, than they actually are, to influence dietary decisions.

77. Food and beverage marketing is pervasive, with the majority of food types marketed to children, influencing their preferences, requests, purchases and eating behaviours. The WHO Commission on Ending Childhood Obesity concluded that “there is unequivocal evidence that the marketing of unhealthy foods and sugar-sweetened beverages ... is related to childhood obesity”.¹⁴¹

78. The obligation to protect sometimes needs direct regulation and intervention, and States parties should consider measures such as restricting the marketing and advertising of certain goods and services to protect public health (see [E/C.12/GC/24](#)). States are obligated to regulate marketing, reduce children’s exposure to food and beverage advertising and ensure that industry provides accurate and easy-to-read nutrition information when advertising its products.¹⁴²

D. Fiscal policies

79. In early 2022, global food prices hit a record high, further worsening food insecurity for millions of people across the world, particularly those living in vulnerable conditions.¹⁴³ As explored in section VIII above, the increase in food prices can be attributed to climate change, conflict and COVID-19. In some parts of the world, the ready availability and accessibility of cheap, unhealthy foods and beverages compared with healthier options has driven up their consumption and, in turn, the rise of diet-related non-communicable diseases.¹⁴⁴

80. In relation to the right to health, “equity demands that poorer households should not be disproportionately burdened with health expenses as compared to richer households” (see [E/C.12/2000/4](#), para. 12 (b)). Taxation and subsidy strategies can redistribute the relative costs of foods, promoting equity and empowering decision-making.¹⁴⁵

¹³⁹ Submission by Global Health Advocacy Incubator.

¹⁴⁰ Silvia Ruiz-Blanco and others, “Green, blue or black, but washing—What company characteristics determine greenwashing?”, *Environment, Development and Sustainability*, vol. 24, No. 3 (2022), pp. 4024–4045.

¹⁴¹ Children living with overweight and obesity may also experience psychological and psychosocial impacts, such as weight stigma, social isolation, depression, low self-esteem and poor educational attainment.

¹⁴² See www.unscn.org/files/Announcements/Other_announcements/A-HRC-26-31_en.pdf.

¹⁴³ See www.imf.org/en/Blogs/Articles/2023/03/09/global-food-crisis-may-persist-with-prices-still-elevated-after-year-of-war.

¹⁴⁴ Barry Popkin and others, “Global nutrition transition and the pandemic of obesity in developing countries”.

¹⁴⁵ Olivier De Schutter, “Taxing for the realization of economic, social and cultural rights”, in *Tax, Inequality, and Human Rights*, Philip Alston and Nikki Reisch, eds. (Oxford University Press, 2019), p. 63; and Initiative for Human Rights Principles in Fiscal Policy, “Principles for human rights in fiscal policy”, May 2021, principle 3.

81. States also have the immediate obligation to take “deliberate, concrete, and targeted” measures towards fulfilling economic, social and cultural rights (see E/1991/23, para. 2). Revenue collected from taxes can allow each State to comply with its obligation to progressively achieve the full realization of rights “to the maximum of its available resources” and “by all appropriate means”.¹⁴⁶

E. Healthy food procurement policies

82. Public procurement refers to the process by which public authorities, such as entities across all levels of government and State-owned enterprises, purchase work, goods or services from private entities – including food and beverages, as well as food services.¹⁴⁷ Food procurement policies tend to favour the lowest cost options, which are often from large-scale, agrifood corporations, while placing minimal value on health and nutrition.¹⁴⁸ The Special Rapporteur on extreme poverty and human rights has stated that “when sourcing food for schools, hospitals and public administrations, Governments have a rare opportunity to support more nutritious diets and more sustainable food systems in one fell swoop”.¹⁴⁹

XI. Policy coherence across food systems

83. Within food systems, health policies designed to address malnutrition can at times be incongruent with policies in other sectors (e.g. economic, agricultural or environmental). Food policy coherence within the food system is critical for improving food systems.¹⁵⁰ Target 17.14 of the Sustainable Development Goals aims to enhance policy coherence for sustainable development.¹⁵¹

84. Women are integral to food systems, performing multiple and central roles across the spectrum of activities.¹⁵² Historic and persistent patriarchal structures have imposed the role of feeding their families on women without also affording them equal access to land, finance, technology and services, compared with men.¹⁵³ As a result, women are more at risk of food insecurity than men, across all regions of the world, especially when a crisis strikes.¹⁵⁴

85. Furthermore, patriarchy in food systems also means that women have unequal bargaining power and influence over key decisions that tend to affect them more severely.¹⁵⁵ Where traditional or customary modes of access are breaking down and being replaced by market mechanisms, a variety of legal, administrative and social norms block increased access to or control over land by women. Women are among the groups, which also include Indigenous Peoples and children, disproportionately affected by harmful business activities, especially relating to land and natural resources (see E/C.12/GC/24, para. 8).

¹⁴⁶ International Covenant on Economic, Social and Cultural Rights, art. 2.1.

¹⁴⁷ See www.oecd.org/gov/public-procurement.

¹⁴⁸ See www.srfood.org/images/stories/pdf/otherdocuments/20140514_procurement_en.pdf.

¹⁴⁹ Ibid.

¹⁵⁰ See https://symposium.bayes.city.ac.uk/_data/assets/pdf_file/0018/504621/7643_Brief-5_Policy_coherence_in_food_systems_2021_SP_AW.pdf.

¹⁵¹ See <https://sdgs.un.org/goals/goal17>.

¹⁵² See https://digital.csic.es/bitstream/10261/280515/1/Sustainable%20food_Rivera_ComCong2021.pdf.

¹⁵³ See www.fao.org/3/cc5343en/cc5343en.pdf, p. xix.

¹⁵⁴ See <https://reliefweb.int/report/world/gender-inequalities-and-food-insecurity-ten-years-after-food-price-crisis-why-are-women>.

¹⁵⁵ Ibid.

86. Recent cases highlight how multinational corporations can evade liability for aiding and abetting child slave labour that occurs on plantations outside where the corporation is headquartered.¹⁵⁶ However, agricultural workers, including children, are also “among the most food insecure, facing formidable barriers to the realization of their right to food, often working without labour and employment protections and under dangerous conditions” (see A/73/164, para. 1). Agricultural workers, who are often also migrants,¹⁵⁷ are not usually paid a fair wage – owing to their uncertain legal status – and are exposed to harmful substances, conditions and hazards, such as pesticides and extreme temperatures (ibid.).

XII. Good practices

87. The national school feeding programme of Brazil guarantees that children’s nutritional needs are met throughout the school year (ibid.) and requires that 30 per cent of the budget is used to purchase food from family farms, prioritizing agrarian reform settlements, Indigenous communities and Quilombola communities.¹⁵⁸ This has created a guaranteed market for fruits, vegetables and grains, shifting many farmers from producing single crops to more diverse production and helping to stabilize rural livelihoods and reduce poverty.¹⁵⁹ The programme showcases that the allocation of a significant part of the budget, coupled with a simplified hiring process, can catalyse the expansion of the healthy food and beverages market and contribute to the realization of human rights.¹⁶⁰

88. Front-of-package nutrition labelling in the form of warning labels has been adopted and is being implemented in several countries, namely Argentina, Brazil, Canada, Chile, Colombia, Mexico, Peru and Uruguay.¹⁶¹ In South Africa, the National Department of Health has published draft regulations to adopt and implement front-of-package nutrition labelling in the form of warning labels.¹⁶²

89. Barbados taxes sweetened beverages in accordance with WHO guidelines, which recommend a tax that raises the price received by the consumer by 20 per cent or more over the final sale price.¹⁶³ By April 2022, the country had already managed to reduce the sale of sugary beverages by 4.3 per cent and increase the sale of unsweetened beverages and water by between 5 per cent and 7.5 per cent.¹⁶⁴ Barbados decided to broaden the base of products covered by the tax and increased the original rate from 10 per cent to 20 per cent to maximize the public health results.¹⁶⁵ In March 2023, Pakistan raised existing excise taxes on carbonated beverages from 13 per cent to 20 per cent and implemented a new tax of 10 per cent on fruit juices, syrups and

¹⁵⁶ See www.supremecourt.gov/opinions/20pdf/19-416_i4dj.pdf.

¹⁵⁷ See www.oecd-ilibrary.org/docserver/9789264288737-en.pdf?expires=1682343084&id=id&accname=guest&checksum=D9F9A1AA6CFD4C9B8F9212C65D1CB7A6; and Liam Richardson and Rachael Pettigrew, “Migrant agricultural workers: a comparative analysis of both policy and COVID-19 response in Thailand, Italy, and Canada”, *SN Social Sciences*, vol. 2, No. 11 (2022), p. 236.

¹⁵⁸ See <https://painelobesidade.com.br/biblioteca/alimentacao-saudavel-nas-escolas-guia-para-municipios/#resumo>.

¹⁵⁹ Ibid.

¹⁶⁰ See www.estudosinstitucionais.com/REI/article/view/726/781.

¹⁶¹ See http://www.globalfoodresearchprogram.org/wp-content/uploads/2023/02/GFRP-UNC_FOPL_maps_2023_02.pdf.

¹⁶² See www.foodfocus.co.za/home/Legislation/Food-Safety/R3337-Labeling-Regulations-for-Comment.

¹⁶³ See www.who.int/es/news/item/11-10-2016-who-urges-global-action-to-curtail-consumption-and-health-impacts-of-sugary-drinks.

¹⁶⁴ See www.who.int/publications/i/item/9789240056299.

¹⁶⁵ See <https://bra.gov.bb/News/Policy-Notes/Excise-Tax-on-Sweetened-Beverages.aspx>.

squashes.¹⁶⁶ In 2018, Peru increased its tax on high-sugar beverages from 17 per cent to 25 per cent.¹⁶⁷ In April 2018, South Africa was the first nation in Africa to initiate a tax on sugar-sweetened beverages, called the health promotion levy.¹⁶⁸

90. Recently, Colombia adopted a tax on ultraprocessed sugar-sweetened beverages and food, with tiered rates distributed across three levels according to sugar content. Taxable products include some dairy products, cereals, jellies, condiments, ice creams and other items with a high content of added sugars, sodium and saturated fats.¹⁶⁹ The tax rate for ultraprocessed foods is set to increase yearly in phases from 10 per cent in 2023 to 20 per cent in 2025.

91. The Ministry of Consumer Affairs of Spain issued draft regulations to limit the advertising of processed products aimed at children. Importantly, Spain has reported difficulties in promoting policies to improve food environments due to severe pushback from certain sectors in society, particularly during legislative and regulatory processes.¹⁷⁰

92. From 2013 to 2017, the Ministry of Health of Malawi, in partnership with the Food and Nutrition Technical Assistance III project, worked to improve the health and well-being of people living with HIV, their families and communities by strengthening the Government's nutrition policies, programmes and systems.¹⁷¹ By aligning nutritional assessments with HIV testing protocols in Malawi, significantly more children, adolescents and adults were identified as having HIV and were connected to treatment that included nutritional counselling and support, improving the adherence to and outcomes of both HIV and nutritional treatment.¹⁷²

93. People who are breastfeeding are effectively delivering a triple-duty action that simultaneously addresses undernutrition, diet-related non-communicable diseases and climate change and other forms of environmental degradation.¹⁷³ Countries such as India have fully legislated the WHO International Code of Marketing of Breast-milk Substitutes in national law and have sustained high-levels of breastfeeding.¹⁷⁴

XIII. Conclusions and recommendations

94. Addressing malnutrition and related health outcomes through food systems reforms is central to global efforts for sustainable development, recognized not only as essential to ending hunger, but also for achieving progress on all 17 Sustainable Development Goals.¹⁷⁵

¹⁶⁶ Pakistan, supplementary finance bill, 2023. "Syrups and squashes, popular in Pakistan, are thick and viscous liquids with high amounts of sugar used to make a drink by adding water", see www.advocacyincubator.org/featured-stories/2023-05-10-pakistan-approves-higher-sweetened-and-sugary-beverage-tax.

¹⁶⁷ See <https://iris.paho.org/handle/10665.2/56103>.

¹⁶⁸ Karen Hofman and others, "South Africa's health promotion levy: excise tax findings and equity potential", vol. 22, No. 9 (2021).

¹⁶⁹ Law 2277, a health tax on ultraprocessed foods and drinks (tax reform), was passed on 13 December 2022. The tax will come into effect in November 2023.

¹⁷⁰ Submission by Spain; see also www.consumo.gob.es/sites/consumo.gob.es/files/Borrador_RD_publicidad.pdf.

¹⁷¹ See www.fantaproject.org/sites/default/files/resources/FANTA-Malawi-909090-Sep2018.pdf.

¹⁷² Ibid.

¹⁷³ Submission by Deakin University.

¹⁷⁴ Rafael Pérez-Escamilla and others, "Breastfeeding: crucially important, but increasingly challenged in a market-driven world", *The Lancet*, vol. 401, No. 10375 (2023), pp. 472–485.

¹⁷⁵ See www.un.org/en/food-systems-summit/sdgs.

95. Food security and nutrition are underlying determinants of health and must be realized to achieve the right of everyone to the highest attainable standard of physical and mental health.
96. Food is more than just the nutrition that it provides. Besides being one of the most common sources of pleasure, food is also a social glue. As a concept, food is certainly more than nutrition; it has always been a special and glorious expression of self, culture and societal, economic and political autonomy.
97. The Special Rapporteur recommends that States and other stakeholders:
- (a) Adopt a comprehensive approach to food systems regulation and the nature and extent of impacts on nutrition and health, from food production to processing and packaging, promotion, distribution, sale and consumption;
 - (b) Analyse food security and nutrition and how they affect health, well-being and spaces such as clinical settings in the management of diseases and the promotion of wellness, which must be multisectoral. Access and outcomes such as intra-household distribution of food, consumption and nutritional status must be measured and monitored and those trends addressed with agility by all stakeholders;
 - (c) Adopt legislative and regulatory measures to protect, promote and support breastfeeding, enabling individuals to deliver this foundational triple-duty action;¹⁷⁶
 - (d) Design and adopt policies to support small-scale and family farmers, which can link production to local food programmes, including school feeding programmes, and local markets through shorter supply chains. These policies can be designed to increase small-scale farmers' income while also reducing the cost and other barriers to healthy and nutritious food for consumers. Specifically, such interventions can be designed to support populations that have a strong connection to the land and have also been historically disadvantaged within food systems;
 - (e) Adopt and revise policies, along with investments in research, technology and infrastructure, to incentivize the production of nutritious foods. Furthermore, biodiversity can be protected through efforts to safeguard rights to land among local communities that depend on the land for their livelihoods, for activities such as farming, herding, fishing and hunting;
 - (f) Address the specific impacts of business activities on women and girls and incorporate a gender perspective into all measures to regulate business activities that may adversely affect economic, social and cultural rights (see [E/C.12/GC/24](#), para. 9), including the right to health;
 - (g) Work, when procuring food to be sold in public settings or programmes, towards the realization of the right to health and health-related rights, given the potential to directly shape food systems and environments in favour of nutrition and health;
 - (h) Be transparent, given the high prevalence of conflicts of interest within fiscal policies, in taxation and subsidies affecting food systems, and prioritize the rights of the population over the private interests of the food and beverage industry;

¹⁷⁶ Rafael Pérez-Escamilla and others, "Breastfeeding: crucially important, but increasingly challenged in a market-driven world".

(i) **Adopt front-of-package nutrition warning labelling on food and beverages containing excessive amounts of critical nutrients, following the best available scientific evidence free from conflicts of interest;**¹⁷⁷

(j) **Adopt a decolonial approach that would refuse such a framing altogether, in particular because, in the era of climate change, environmental destruction is often attributed to the reproduction of those living in poverty, Indigenous Peoples and people of African descent;**

(k) **Regulate the advertising of unhealthy products, reduce children’s exposure to aggressive marketing by banning companies from advertising unhealthy products to children below a certain age, and restrict the availability of unhealthy foods and their advertising in school settings (see [A/HRC/26/31](#), paras. 22–25);**¹⁷⁸

(l) **Advance both human and planetary health and ensure that current food systems do not compromise the ability of current and future generations to secure their own rights to food, health and livelihoods. States must also promote the conservation, protection and restoration of the health and integrity of the planet’s ecosystems, including through sustainable healthy food production and consumption based on ecologically sound methods within planetary boundaries, while ensuring resilience to future crises, including those caused by conflict, pandemics and climate change;**

(m) **Protect and promote the right to healthy working conditions and food security of workers in the entire sector, as it is important for them to realize their economic, social and cultural rights;**

(n) **Move towards substantive equality, which requires starting with those furthest left behind and ensuring that all efforts are in the service of the restoration of dignity of all people. States must build food systems based on the culture, identity, tradition and social and gender equity of local communities that provide healthy, safe, accessible, affordable, diversified and nutritionally and culturally appropriate diets;**

(o) **Help to identify, through the constituent components of accountability, namely monitoring, review and redress, where progress has been made and where it is lacking, and allow rights holders to seek redress for violations where they have occurred. Accountability constitutes a way for duty bearers to explain their actions and adjust;**

(p) **Create conditions that are conducive to a life of dignity and take seriously the “fostering [of] fond memories and family bonding through ‘living off the land’, enabling experiential intergenerational teaching and learning, and promoting resourcefulness and offsetting economic marginalization”.**¹⁷⁹

¹⁷⁷ See www.ohchr.org/en/statements/2020/07/statement-un-special-rapporteur-right-health-adoption-front-package-warning.

¹⁷⁸ See also www.who.int/publications/i/item/9789241500210.

¹⁷⁹ Catherine McKinley and others, “‘Living off the land’: how subsistence promotes well-being and resilience among Indigenous Peoples of the Southeastern United States”, *Social Service Review*, vol. 92, No. 3 (2018), pp. 369–400.