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Editorial Brief

The Centre of Excellence in Global and Migration Studies (CEMGS) is a 2019 Tertiary Education Trust Fund (TetFund) intervention that commenced operation in March 2020. It was founded by Professor Abdallah Uba Adamu, who from 2016-2020, was the Vice Chancellor of National Open University of Nigeria (NOUN). This Journal is one of the academic publications of the Centre that is deemed crucial to fulfilling the vision of the founder. We should note that global migration and mobility has become part of human history and cannot be divorced from developmental plan, economics, politics, social life, and education of the citizens. Both internal and external migrations have come to influence who we are, what we do, and our future. NOUN's CEMGS is therefore a milestone in the history of the institution. The Centre serves as the fulcrum of research on migrations, both internal and external; and its conceptualisation, contextualisation, and decolonisation as essential to multidisciplinary analyses of global studies.

The International Journal of Migration and Global Studies (IJMGS) is a critical and Afrocentric-centred Journal that engages theories, concepts, and real life narratives on migrations in the locale, national, or global dimension. The Journal articles are policy oriented, adaptable for teaching, and solution driven in analysis; they are useable nationally and globally.

With several factors responsible for internal, intra-regional, continental, and global movement of peoples, the Centre with the birth of its academic Journal, hopes to sustain documentation of experiences through arts methods, science and health methods, other social science methods for use in the classroom, policy making, and for experiential learning.

It is hoped that the articles in this maiden edition, and subsequently, will fulfil the purpose, rationale, and aspiration of the Journal.

Hakeem I. Tijani
Editor

Constraints in Globalization: Nutrition and Diet in Perspective

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Abstract
While the impact of globalization cannot be overemphasized, there is a downside of the policy which is its implication in diet as a risk factor of non-communicable diseases. Studies indicate an increased consumption of western diet rich in saturated fats, salt, processed foods and a reduction in staple traditional foods. This nutrition transition has been implicated in the paradigm disease shift from communicable diseases, which has otherwise plagued sub-Saharan African to no communicable diseases. The central objective of this paper is to investigate how nutrition transition as a result of globalization affects traditional dietary pattern; the study based on health framework is used to explain the complex inter-relationship between globalization and nutritional transition. We conduct a desk analysis of literatures on medical sciences, epidemiology study, economic policies, in sub-Saharan Africa; the findings from this study are used to suggest appropriate policy that enhance trade and policy in sub-Saharan Africa.

Keywords: globalization, nutrition transition, non-communicable diseases, diet.

Introduction

The UN General Assembly in 2011 declared that one of the major challenges for development in the twenty first century is the threat of non-communicable diseases. Non-communicable diseases often called chronic diseases are diseases of long duration with generally slow progression. They are characterized by multi-morbidity, and they occur as a consequence of one leading index condition. The four major types of Non-Communicable Diseases are cardiovascular diseases (like heart attack and stroke), cancers, chronic respiratory diseases (such as chronic obstructed pulmonary disease and asthma) and diabetes. Even though it is a global issue, NCDs are said to disproportionately affect low and middle income countries with an approximated 85% deaths directly linked to NCDs. NCDs are also rising faster in younger populations in low and middle income countries than in high income countries. Cervical cancer is the leading cause of death from cancer among women in sub-Saharan African while ninety percent of children with leukemia in the world's twenty five poorest countries die from it. (Roberts: 2011) According to the Kenya National Strategy for the

Prevention and Control of NCDs 2015-2020 report, (Ministry of Health, 2015 Ministry of Health Statement of Intent 2015-2019) Africa will experience the largest increase in NCD deaths by 2020. Further by 2030, NCD related deaths are projected to surpass the combined deaths of communicable and nutritional diseases and maternal and prenatal deaths. (WHO: 2013)

With the soaring cost of treating NCDs, the buzz word is ,,preventionee. To this end, the UNGA recommended the adoption of cost-effective best buys (UNGA :2011) to reduce the impact of the four main NCD risk factors, namely tobacco use, the harmful use of alcohol, unhealthy diet and lack of physical activity. From available scientific investigations and studies, the NCD pandemic is a public health challenge that has roots in economic growth and globalization of food markets. Scholars have argued on the adverse effect of international trade policies on economies and are deserving attention in this paper.

This article emphasizes the impact of globalization on diet or nutrition transition, and the impact of globalization on state effort to encourage healthier diets. Globalization, like health influences individual and societal aspects. The paper contributes to the thinking process about globalization from the health and nutrition perspective in developing countries. The health perspective provides an excellent area of evaluation because it is fundamental to human existence and the dignity of human life is measured in terms of wellness. The research work seeks to be a doorway into critical conversation on how future public policies are framed in shaping the future and suggests how policies will stimulate better nutrition to boost population health and how states could protect its members without violating international obligations.

To this extent, this work builds on outcome of investigative studies, systematic reviews and scientific studies to propose a review of relevant rules revolving round nutrition. This work considers relevant framework that would stimulate proper trade rules in respect of nutrition and how multi sectoral framework can be harmonized to optimize population health. However, this work is streamlined because of the fact that NCD is a multi•

level approach requiring different levels of intervention with mechanisms between different levels of intervention. Also, unhealthy nutrition as a factor

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requires a wide range of stakeholders, this work, for practical reason, will limit to themes relating to fast food and importation.

Part I relates to the well-established phenomenon of the global NCD pandemic, including its effects and assumed causes. Part II establishes the NCD global pandemic, its causes and effects. In doing this, it focuses more on developmental and socio-economic effects ofNCDs on states. Part III of this research looks at the effect of food related policies in Nigeria while Part IV analyses different.

Backgroundand Context

The NCD Pandemic: HealthEffects and Contributors

Although the emergence/rise of non-communicable diseases is as a result of many factors, the emergence/rise of non-communicable diseases in Nigeria has been greatly influenced by two significant factors. These factors include the nature and character of the Nigerian state; and, trends and development in the international economy.

The emergence of the Nigerian state meant that it was first a colonial and then a neocolonial and non-autonomous capitalist. The advent of British colonialists played a significant role in the development of Nigeria. Their presence introduced indigenous Nigeria to trade activities between the indigenous merchants and the British in coastal areas such as Calabar and Lagos. (Uweru 2014). The settlement led to rapid development of urban and rural settlements. In terms of human development, urbanization trend has since accelerated its pace and has been on an incremental rate with urban population at 49.5% in 2017. When Nigeria gained independence in 1960, there were 45.2million people living in Nigeria; Distribution of population in Nigeria into urban and rural areas with more than 50% of the Nigerian population residing in the rural areas. (WHO Health Statistics 2014a) Available statistics reveal that the population in most major towns such as Lagos, Kano, Port Harcourt, Maiduguri had over 1,000percent increases over ten decades. For instance, Lagos rose from less than 1million in 1963to over 4million in 1982 while Enugu inhabitants rose to 850,000 from 174,000 (Onibokun, 1987a). Currently, Nigeria has 198,000 million inhabitants with

an average population growth rate of 2.6%. (Nigerian Population 2019). Between 1968 and 2017, urban population in Nigeria grew from 17.3% to

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49.5% at an increasing annual rate. The transformation from colonial settlements triggered off corresponding wealth in Nigeria.

The second factor that influences the four risk factors outlined above in Nigeria is the trend in international economy. 1870 to 1913 was the age of laissez faire economy which expanded international trade (Nayyar 2006), and industrialization, followed by globalization which led to unprecedented expansion of international trade. Globalization is characterized by interflow and linkage of networks of interactions including goods and services amongst regions and nations which lead to economic growth.

Economic growth implies income growth. Whereas in western countries, where people buy more healthy foods as income rises, developing countries, as Nigeria, buy more unhealthy foods - thus, there is a pattern shift from coarse grains, legumes and vegetables towards high-fat, high sugar, refined carbohydrates, and animal source foods. Market liberalization has further allowed diet diversification from the traditional African diets to fast food diets. (Kola et.al www.fao.org.docrep/pdf/007 /y5736e/y5736e01.pdf) With economic growth and development comes a growth of the service sector and sedentary lifestyle, replacing physical activity/labour; reliance on mechanized transportation, increased mode of transportation which reduces physical activity; weight gain and unwholesome diet increases the likelihood of diabetes for both men and women.

The international economic order has also influenced the penetration of multinational companies in Nigeria into every sphere of market activities. For instance, in the tobacco industry, there has been an increase in intake of tobacco use and alcohol consumption in the last few years in Nigeria. There are more brands, and with increased and inviting promotions and freebees and sales promo for frequent consumers. This is coupled with the fact that Nigeria is one of the highest producers of tobacco in Africa. (Ade-Famuyide 2018)

Understanding Globalization

The concept of globalization has been used as a descriptive as well as a prescriptive concept. It implies, in the descriptive sense a seamless trans• border trade, information and finance and, in the prescriptive sense, it necessitates deregulation of national economies for cross-border trade,

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investment and information.

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A central mechanism of globalization is the integration of the global marketplace which imparted on dietary pattern in three processes: Cusimano discusses these three processes as advantages of globalization fewer than three heads; the spread of information; the interlocking technologies and specialization of services (Cusimano Love, 2004). Firstly is the production and exchange of goods in the form of agricultural production; Viewed from this perspective, globalization is described as the process of increasing economic, political and social interdependence and global integration that take place as capital, traded goods, persons, concepts, images, ideas, and values diffuse across state boundaries. (Burrel and Woods, 1995). In a globalized agricultural market, nations produce food consistent with their resource endowment. By the theory of comparative advantage, there is greater efficiency, lower cost of production and cheaper food. The outcome of the integrated market has enabled different food trade, and the enlargement of transnational food companies.

Secondly is the flow of investment across borders. The most commonly understood aspect of globalization is cross-boundary flow of services, labour, technology, products, services and information within a global system of independent economic, political and socio-cultural relations. (Harris & Seid, 2004) Cross-border flow of trade allows companies to buy and sell in other countries through foreign direct investment (FDI). Cross border trade includes foreign direct investment (FDI) and indirect investment or portfolio. The FDI is the package of capital, technology; management and entrepreneurship which allows a firm operate and provide goods and services in a foreign market. (Farrell 2008) One of the things that have brought huge changes to the food trade is the removal of trade barriers and the increasing incentives to transnational businesses. FDI has played a huge role in the nutrition transition through the increase in importation of processed foods in Nigeria. Through the removal of de-incentives, there are lower prices, more channels, increased marketing and advertising and more sales.

The third factor is the global communication. Thus, Giddens (1990) describes globalization as the intensification of social relations on a worldwide scale. Communication and technological advancement interplay

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with globalization; technological advancement reduces physical activities and labors and shifts food consumption to fast, unhealthy options.

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Globalization: virtues and vice

Analysts of globalization have argued on the enormous potential benefits due to cross-fertilization of ideas, culture and processes. While this cannot be overemphasized, the World Health Organization has stated that "globalization is under trial, partly because these benefits are not spread equally and not yet reaching hundreds of millions of world's poor, and partly because globalization introduces new challenges". (WHO 2001:1). This position was confirmed by Cusimano who opined that globalization exacerbates the excesses of capitalism. And as noted by the WHO, poor countries and the disadvantaged bear the greatest burden of health risk (WHO

2002: 13). Part of what makes globalization a problem from the health and diet perspective is that increased globalization of markets through international trade affected the dietary habits of peoples in developing countries. (David P. Fidler, 1999). Foreign direct investment (FDI) favours less healthy foods in developing economies; market stereotypes influences the developing countries to prefer western products;

Globalization and health

Within the public health domain, it is argued that globalization poses much as risk as its blessings because, while global economic and technological advancements have enhanced life expectancies, socio-environmental conditions, cross-cultural living have exacerbated the prevalence of communicable and non-communicable chronic diseases. McMichael and Beaglehole (2000) in their work argued that globalization is a major determinant of national health policies. Viewed from this perspective, globalization has integrated trading goods and transformed companies into transnational corporations which are able to operate in more countries than one at the same time. Globalization affects dietary habits through processed food exports which contribute negatively to changes in dietary patterns. A good example is the *bigfood industry*, the term used to refer to multinational food and beverage companies responsible for accelerating the global rise in the promotion, purchase and consumption of low-cost, highly processed foods and sugar-sweetened beverages (SSB). These products are poor in

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nutrition, high in sugar, salt and saturated fat and have been linked to NCD. (Stuckler and Nestle: 2012). This includes coca cola, PepsiCo, Nestle, Phillip

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Morris international, Kentucky Fried Chicken, etc. The authors further revealed potential risks of globalization on primary health, including, income differentials; weakening of labour markets; land degradation; spread of smoking related diseases; diseases of dietary excesses; public health consequences of private car ownership; urbanization and its attendant consequences; spread of infectious diseases; prevalence of depression.

The link between globalization and diet is the adaptation and divergence of diet. Divergence has been defined as the "increased reliance on a narrow base of staple grains, increased consumption of meat and meat products, dairy products, edible oil, salt and sugar and a lower intake of dietary fibre." Convergence is ,,increased consumption of brand name processed and store• bought food, an increased number of meals eaten outside the home and consumer behaviours driven by the appeal of new foods available" (Kennedy, Nantel and Shetty 2005). Both theories have been linked to the increase in wealth or income and the presence of transnational corporations, both as a result of globalization of foods and services.

Nutrition transition

The term "nutrition transition" is used to describe the change of dietary noticeable as there is an increased level of economic development such as increase in income and status. This theory was first proposed by Popkins, an economist agriculturist in 1993 to explain the increasing frequency of chronic health conditions. According to Popkin'ls theory, industrialized diet is a diet high in animal protein, highly refined sugar, trans fat and high sodium content. This diet replaced the traditional diet. Popkin also noted that diets high in *trans fat,* sugars, salt, ultra processed foods and meat products are well underway in the world's poorest population. (Popkin 2002). The industrialized diet, also known as the western diet is a high caloric diet stems from fats, sugar animal products and low in nutrients as against the traditional diet. Dietary transition is rooted globalization. This is because globalization is associated with changing incomes and lifestyles. The impact of this diet is a high risk of cardiovascular disease, diabetes, cancers and other diseases associated with the western diet.

According to Kennedy, Nantel and Shetty, (FAQ 2004):

"globalization is having a major impact on food systems around the world... [which] affect availability and access to food through changes to

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> food production, procurement and distribution….in tum bringing about a gradual shift in food culture, with consequent changes in dietary consumption patterns and nutritional status that vary with the socio• economic strata"

Globalization and Chronic disease (NCDs) in Nigeria

In 2014, the WHO declared that NCDs accounted for 24% of deaths in Nigeria (WHO. Country profile 2014) while Ekpenyong et.al (Ekpeyong 2014) posited that the overall prevalence ofNCD in Nigeria was 32.8%. The Nigerian Federal Ministry of Health corroborated this by saying that more Nigerians are now living with NCDs especially, diabetes, cancer, heart diseases and hypertension. (Ayodamola Premium news online). In 2018, the WHO Regional Director for Africa lamented that African region has the highest level of hypertension in the world with about 30 percent of adults suffering from the disease. A WHO study shows that approximately 250,000 cancer cases are diagnosed yearly.

Nigeria is currently facing a double of disease of communicable and non-communicable disease. The proportion of deaths from chronic diseases has increased significantly with hypertension, diabetes, cancer and chronic kidney diseases (CKD) accounting for about 40% of all deaths. Diet or unhealthy nutrition has reached a worrisome level with the current dietary pattern in Nigeria. Poor dietary habits contribute to about 2.8million deaths each year. The nutrition transition to western diet and reduction are all driving the rise in chronic diseases. Studies have shown that these foods high in salt, fats and sugar contribute to the increased risk of NCDs, including diabetes, cardiovascular and cancers. As such, policies must be framed in such a way to capture the essence of globalization, filter through the concept as to screen out the vices and ensure that the benefits are facilitated to transit to a more desirable outcome.

To this end, my evaluation of the adverse effect of globalization on health is in two folds: (i) food importation and, (ii) consumption of food outside the home, which are practices further developed at the advent of globalization.

Food importation

International trade is a major contributor to the prevalence ofNCD in Nigeria because it has been used to open developing economies to exports from

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developed country companies. This, in the opinion of David (David Fidler 1980),

> 'developing countries made ideal emerging markets because they did not have the sophisticated public health and regulatory systems that were increasingly making tobacco companies lives in developed counties difficult'.

Agriculture was the mainstay of the economy that contributed to national revenue and foreign exchange receipts. In the 50s and 60s, commercial agriculture contributed 64.1% and 55.4% of national output in the country in 1960 and 1963 respectively through produce such as cocoa, peanuts, palm oil, rice, millet, cassava, yams, rubber, cattle, timber and fish (Eghosa et.al 2002). However, there was a shift from growing food to global trade. Thus, in 1980, African exports represented 5.9% of world exports which by 1996 had fallen to 2.3%. (David P. Fidler). Food importation, on the other hand has continued to increase with statistics showing that Nigerian imported an average of Nl ,923 trillion worth of commodities per annum in the period between 1990-2011.(CBN 2006).

By the first quarter of 2019, agricultural imports to Nigeria stood at 61.3% (Trading Economics). The significant change and dependence of food imports show that food habits and dietary patterns in Nigeria, as in many Sub-Saharan countries have been greatly influenced by the imports. Dietary pattern has changed from the traditional diet of high fibre to manufactured, processed and prepackaged foods.

Imports, 2006 - *(Nbil)* 201O* *Commodity*

Major Food	*Total Import (Nbil)*	*Average Import/yr.*	*Ranking*

Wheat	823.84	164.77	1st
Prepared cereals	159.60	31.92	6th

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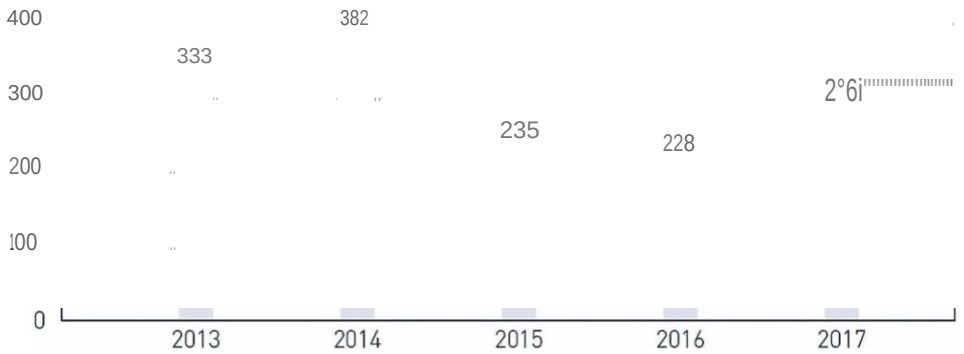
Fish	568.17	113 63	2nd
Milk/Dairy	312.57	62.51	3rd
Sugar	193.07	38 61	5th
Rice	271.19	54.24	4th
Cocoa	3.31	0.66	10th
Oils	104.82	20 96	8th
Oil seeds	25.51	5.10	9th
Prepared Vegetables	111 98	22.40	7th & Fruits

Source: NBS imports data

The Table reveals that most of the foods implicated in NCD risk factors constituted the highest imports in 2006-2010. Oil seeds (32.13bn); dairy (N1.73bn); prepared cereals (N1.69bilion naira); between the periods 2006-2011, Nigeria's daily import was about $USD9.28m per day Increased sale of ultra-processed food imports which have been preserved by salt and sugar leads to more non-communicable diseases in the country. (Vanghan, Afolami, Oyekale & Ayegbokiki 2014).



This figure represents Nigeria's imports of food, beverage between 2013-2017. Sourced online from https://www.agrofood-nigeria.com/food-bev-tec-nigeria.htmlr.

Literatures have associated the globalization of markets for processed foods to the change in dietary pattern of people in developing countries.

Food consumption outside the home

The term "fast food", refers to food that can be served at an outlet to consumers. This can be either sit-in or takeaway packages (Olonilebi 2017). Foods commonly served in fast food outlets include pastries, ice-creams, chips, fries, sandwiches, pizzas, noodle, frizzy drinks among other foreign delicacies etc. The penetration of international brands with high level of competition has led to the adoption of different modes of services amongst fast food outlets - from the introduction of local dishes, which cater for traditional cuisines, as for instance, introduced by Sweet Sensation in its *Africana*, and later adopted by Tantalizers and a host of others. There was also the introduction of specialization, in which restaurants specialize in the production and sale of products such as Pizza Inns, Creamy Inn, MacDonald's, Kentucky Fried Chicken (KFC) etc. From a health perspective, there is a strong link between increased chronic conditions and food consumption outside the home. Fast foods are high in fat, sodium, sugar and processed foods. According to David, the penetration of these US fast food diets in form of cross-border investment in the fast food contribute has paved the way for the proliferation of hotels, restaurants and food investors such as supermarkets and food merchants. This penetration of fast food into diet and lifestyles of developing countries and the proliferation of fast food chain stores are part of development associated with westernization, industrialization and urbanization.

Studies have associated the increased consumption of fast food and the increasing NCD rate due to excessive intake of high caloric foods containing *transfat*, ultra processed foods containing high sodium content. Restaurants prepare cheap meals with high fat and caloric content. These changes in food pattern from homemade meals to fast foods form part of the concerns about the emerging NCD pandemic. Higher availability of fast food services is associated with higher mortality and hospital admission rates for cardiovascular diseases, diabetes, high blood pressure as well as risk of overweight and obesity. Consumption of fast food has led to increased weight gain, diabetes, cardiovascular conditions, etc. (Zahra, Mirmiran and Azizi 2015) For instance, increased consumption of burger, fried chicken meals, sausage and other processed foods was implicated in the rise of type

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2 diabetes (Micha, Wallace and Mozaffarian 2010). A 2005 study (Alter and

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Eny 2005) also associated the rise in cardiovascular diseases with the increase in consumption of fast food products.

Conclusion

Towards policy intervention to combat NCD and reap from globalization since the awareness of the impact of international trade on health, there have been a lot of policy interventions taking place. The Global Strategy has four objectives (i) reducing the risk factors of chronic non-communicable diseases that occur from unhealthy diets and physical inactivity; (ii) creating awareness of the positive health effects of preventive interventions (iii) encouraging the implementation of global, regional, national and community policies and action plans to improve diets and physical activity.

A lot of lessons could be gleaned from countries that have successfully adopted approaches that, on the one hand reaped the gains of international trade and, on the other hand, reduced the NCD incidence. For instance, the United Kingdom developed the scheme for nutrition labeling using traffic light symbols. The Food Standards Agency, Front-of-pack traffic light signpost labeling technical guidance (2007) uses traffic light colors to help people understand how their diet choices affect their health. Under this scheme, there are separate information concerning fat, sugar, and salt using different colours to indicate the levels of nutrients. Sweden, has developed food stamps/labels to indicate that a product has a small amount of total fat, saturated fatty acids, trans fatty acids, added sugars and salt (Stephen, 2009).

Similarly, New York, recognizing that most New Yorkers consume at least a third of their calories away from home, enacted the New York City Health Code Section 81.50 requiring fast foods to provide calorie information which are prominently displayed on menu, menu tags and item tags. The State of California has enacted the Cal. Health & Safety Code (2010) a law requiring food stores to provide nutrition information in their food, and a standard menu tag should disclose calorie content information net to the item on the menu.

A humanrightto nutrition

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This recommendation is a spring board upon which all other recommendations flow. Food sustains the human body, and is pivotal to the protection of the right to life. Thus, proper nutrition is essential to health and

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life, inversely, unhealthy food is a deterrent to the realization of this right A right to nutrition recognizes that protection from certain foods is very important to human health because a diet inundated with low calorie foods are a microcosm of the larger picture of the challenge. With the recognition that diet is a major factor, this recommendation advances the argument from the constitutional point of access to nutrition, and conversely, the protection from unhealthy diet.

The right to nutrition is first of all, a right to food. This class of rights is grouped under the socioeconomic rights, such as the right to housing, education and the right to health care. While the FAO reports that more than 23 countries have included the right to food in their domestic constitutions, Nigeria does not explicitly protect socio economic rights.

Under the international human rights regime, Article 12 of the Universal Declaration of Human Rights (UDHR, 1948) recognizes the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (ICESCR, 1966). In this light, it has been argued that states must protect this right by ensuring that everyone within their jurisdiction has access to the underlying determinants of health (Martin and Saskia, 2013).

Similarly, Article 25 (ICESCR 1966) states thus:

> "Everyone has the right to a standard of living adequate for the health and well-being of himself and his family, including food, clothing, housing and medical care..... "

A joint reading of articles 12 and 25 provides the most comprehensive article on the right to health in international human rights law.

Tortious negligence

A number of claims have arisen where claimants attempted to hold fast food restaurants responsible for contributing to chronic diseases by suing them in tort and through other causes of action. In the popular case of *Pelman v. McDonalds,* a group of New York City teenagers filed a putative class action seeking compensatory and punitive damages from McDonald's claiming that McDonald's engaged in negligent and deceptive practices caused obesity and

other related health problems. Even though the case was dismissed on personal responsibility, the point has been made on the prohibition of

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deceptive acts and false advertisements. It has also been argued that fast food restaurants constitute public harm to the community at large.

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