UNIVERSITY OF KWAZULU-NATAL
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Developing and applying a constitutional rights-based approach to the regulation of the modifiable risk factors for non-communicable diseases in South Africa

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ABSTRACT

Non-communicable diseases (NCDs) caused by unhealthy diet, contribute significantly to South Africa's burden of disease and are preventable. Policies and laws offer an evidence-based mechanism improve diet and prevent NCDs. However, the adoption of these measures is complex, often facing opposition from many actors. To address these challenges to the adoption of these interventions, scholars have looked to develop human rights-based (HR-based) approaches to the prevention of obesity and diet-related NCDs. These approaches have the advantages of supporting and guiding government action on NCDs, holding various actors accountable and providing a means to manage the competing rights implicated in NCD prevention efforts. However, to fully realise the benefits of an HR-based approach to NCDs, there is a need to anchor the approach in context-specific rights married with concrete and enforceable obligations. This thesis seeks to develop an HR-based approach to NCDs under the rubric of the South African Constitution. Often the right to health or the right to food can form the basis of an HR-based approach to NCDs. However, the peculiarities of section 27 of the Constitution require that the content of these rights be further developed to encompass NCD prevention, particularly where the interventions sit outside the healthcare system and are not biomedical in nature. This thesis explores and develops the content of the right to healthcare and the right to sufficient food to identify obligations that could support action on NCD prevention. Recognising that NCD prevention interventions may limit individual rights, this thesis then explores the relationship between public health and HR through the lens of colliding rights and section 36. Since many NCD prevention interventions may be novel, there arise implications for the section 36 limitations analysis. This thesis therefore addresses the application of section 36 analysis to novel NCD prevention interventions, outlining the kinds of considerations influencing whether the limitation of rights by a public health intervention can be found to be justifiable. This thesis with recommendations on how this HR-based approach may be used in South Africa to prevent NCDs.

ABBREVIATIONS

AIDS – Acquired Immunodeficiency Syndrome
ARV – Antiretroviral
AU – African Union
CDOH – Corporate Determinants of Health
CEDAW - Convention on the Elimination of All Forms of Discrimination against Women
CESCR – Committee on Economic, Social and Cultural Rights
COGTA – Cooperative Governance and Traditional Affairs
COSATU - Congress of South African Trade Unions
CRC - Convention on the Rights of the Child
DMA – Disaster Management Act No. 57 of 2002
FAO - Food and Agricultural Organization of the United Nations
HR – Human Rights
HIV – Human Immunodeficiency Virus
ICESCR – International Covenant on Economic, Social and Cultural Rights
LMICs - Low- and Middle-Income Countries
NCDs – Non-Communicable Diseases
NPI – Non-Pharmaceutical Intervention
NSNP – National School Nutrition Programme
SAHPRA – South African Health Products Regulatory Authority
SDOH – Social Determinants of Health
SSB – Sugar-Sweetened Beverage
TB - Tuberculosis
UDHR – Universal Declaration of Human Rights
UN – United Nations
UNGA – United Nations General Assembly
WHO – World Health Organisation
WTO – World Trade Organisation
XDR-TB – Extensively Drug-Resistant Tuberculosis

CONTENTS

ABBREVIATIONS 4
CONTENTS 5
CHAPTER 1 1
I. The epidemic of preventable non-communicable diseases 1
(a) The growing problem of non-communicable diseases in South Africa 2
(b) Causes of the NCD epidemic in South Africa 3
II. POLICY and LEGAL RESPONSES TO THE NCD EPIDEMIC 3
III. Regulation of risk factors in South Africa 6
(c) Difficulties in implementation of NCD prevention interventions 9
IV. The role of human rights in the response to NCDs 11
V. The need for a constitutional rights-based approach 12
VI. Research Question, aim And objective 12
VII. Research design and methods 13
VIII. The impact of COVID-19 on this thesis 13
IX. Structure of the thesis 13
CHAPTER 2 15
I. Introduction 15
II. Characterising the role of human rights in NCD responses 20
III. Role of an human rights-based approach in NCD prevention 24
IV. The application of human rights to NCDs 25
(a) The right to health 25
(b) The right to food 27
V. A human rights-based approach to NCDs in the African Region 30
VI. Need to develop a human rights-based approach that is context specific to South Africa 32
(a) The approach adopted in South African policies 33
VII. Conclusion 34
CHAPTER 3 35
I. Introduction: 35
II. The right to health as more than a right to healthcare 35
III. The scope of the right to health under international law 38
(a) The right to health as defined by human rights instruments 38
(b) The right to health under population-specific treaties 41
(c) The scope of the right to health under regional instruments 43
IV. Right to health under South African Law: Constitutional Provisions 45
V. The development of right to health jurisprudence in South Africa 47
(a) Defining the content of the right to healthcare 47
(b) Application of section 27(1)(a) to non-pharmaceutical interventions 51
VI. Discussion 61
VII. Conclusion 62
CHAPTER 4 64
I. Introduction 64
II. Changing food environments as a driver of NCDs 65
III. content of the right to food under international law 66
(a) Recognition of the right to food and nutrition under international human rights instruments 66
(b) The right to food under regional African instruments 70
IV. Content of the right to food in the South African Constitution 73
(a) The right to food under section 27(1)(b) 74
(b) Sufficiency versus adequacy under the South African Constitution 75
(c) The content of the right to food under section 28 – children's rights 77

(d) The right to food under section 35(2)(e) – prisoner's rights ... *79*
V. The content of a right to nutritious and healthy food under the Constitution: The interrelationship between the right to food and other constitutional rights ... *81*
VI. Conclusion ... *84*
CHAPTER 5 ... 85
I. Obligations under socio-economic rights in the Bill of Rights ... *85*
II. Obligations under the right to healthcare ... *86*
III. Obligations under the right to Healthy food ... *87*
(a) Physical accessibility ... *89*
(b) Economic accessibility ... *90*
(c) Nutritional adequacy ... *90*
(d) Obligation to protect ... *91*
IV. Conclusion ... *93*
CHAPTER 6 ... 95
I. Introduction ... *95*
II. The role of human rights in public health responses ... *97*
(a) A historical overview ... *97*
(b) The three phases of the relationship between human rights and public health responses ... *99*
III. South Africa jurisprudence on human rights in epidemics ... *106*
(a) The role of human rights in South Africa's NCD jurisprudence ... *109*
(b) The role of human rights in South Africa's Covid-19 jurisprudence: defining the relationship in a modern epidemic ... *111*
(c) The approach of COVID-19 jurisprudence ... *120*
IV. Conclusion: lessons for NCD prevention ... *123*
CHAPTER 7 ... 124
I. Introduction ... *124*
II. Overview of section 36 ... *126*
III. Considerations emanating from jurisprudence ... *130*
(a) Severity of the epidemic ... *130*
(b) Effectiveness and the evidence base supporting the intervention ... *132*
(c) Necessity of the intervention ... *134*
(d) Impact on other rights ... *136*
(e) The negative externalities of individual conduct ... *136*
IV. Factors influencing the constitutionality of the tobacco ban: a case Study ... *137*
V. Application to NCD Prevention interventions ... *144*
VI. Conclusion ... *145*
CHAPTER 8 ... 146
I. Introduction ... *146*
II. Summary of main conclusions ... *147*
III. Recommendations and concluding Remarks ... *149*
BIBLIOGRAPHY ... 151
I. Primary Sources ... *151*
(a) Legislation ... *151*
(b) Draft Bills ... *151*
(c) Regulations ... *151*
(d) International Instruments ... *151*
(e) Case Law ... *153*
(f) Foreign Case law ... *154*
(g) Policies ... *155*
II. Secondary Sources ... *155*
(a) Journal Articles ... *155*
(b) Books ... *162*

(c) Unpublished Theses and Papers *163*
(d) Online Resources *164*
(e) Reports *165*
(f) Newspaper Articles *166*

List of Figures

Figure 1: State human rights obligations at the centre of the obesity response (non-exhaustive list) from Patterson et al 19
Figure 2: How human rights-based approach can advance the obesity agenda from Patterson et al 24
Figure 3:Duty bearers under a Human Rights-based approach to prevention and control of NCDs developed from Nygren-Krug's description of potential duty bearers. 91

List of Tables

Table 1: Legal Interventions to Prevent and Control NCDs 5
Table 2: The implementation of Policy options for member states under Global Action Plan for the prevention and control of NCDs 2013-2020 in South Africa 7
Table 3: Right to Food Obligations for NCD prevention under the Respect, Protect, Promote and Fulfil Framework 88
Table 4: Protect, Respect, Remedy Framework as applied to NCD prevention 92
Table 5: Legal Interventions to Prevent and Control NCDs 124

CHAPTER 1
INTRODUCTION

There are growing concerns about the increasing prevalence of non-communicable diseases caused by unhealthy diets in both South Africa and sub-Saharan Africa. It has been acknowledged that this epidemic is driven by food environments rather than individual choices. By reshaping food environments through evidence-based policies and laws, these diseases can be prevented and the epidemic controlled. Human rights and, in a constitutional democracy such as South Africa's, constitutional rights can play a pivotal role in guiding state action and supporting the adoption of these policies. However, human rights may also be weaponised by opponents of these policies to hinder or challenge their adoption. This thesis seeks to develop the socio-economic rights to food and health as a mechanism to support the prevention of diet-related NCDs and explore how competing rights may be managed to ensure the promotion of public health.

I. THE EPIDEMIC OF PREVENTABLE NON-COMMUNICABLE DISEASES

Non-communicable diseases collectively cause the greatest number of deaths globally and presently account for a staggering proportion of deaths in low- and middle-income countries.[1] Stroke, diabetes, heart disease, cancer and chronic lung disease –make up the bulk of morbidity and mortality from non-communicable diseases.[2] These diseases also share four modifiable risk factors (also referred to as the corporate determinants of health) which are understood to be preventable: the use of tobacco; alcohol consumption; unhealthy diet;[3] and a sedentary lifestyle.[4] Diseases which develop as a result of poor diet or obesity are known as food- and obesity-related non-communicable diseases (NCDs) – the sub-set of non-communicable diseases which forms the central focus of this work.

Though communicable diseases remain the biggest cause of morbidity and mortality in Africa, NCDs remain a close second.[5] This double burden of disease – and the chronic nature of treatment – has placed immense pressure on already strained health systems in developing countries. This has resulted in the populations of developing nations not only exhibiting a higher prevalence of NCDs, but also worse health outcomes than their counterparts in developed nations.[6] As a result of globalisation, the patterns of consumption typical of

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[1] Majid Ezzati, Jonathan Pearson-Stuttard, James E. Bennett et al 'Acting on Non-Communicable Diseases in Low- and Middle-Income Tropical Countries' (2018) 559 *Nature* 507 at 507.

[2] World Health Organisation 'Major NCDs and their risk factors' available at http://www.who.int/ncds/introduction/en/, accessed 1 November 2017.

[3] An unhealthy diet is currently defined as a diet comprising of excessive consumption of ultra-processed foods, trans-fats, salt and sugar. See Robert Beaglehole and Derek Yach 'Globalisation and the Prevention and Control of Non-Communicable Disease: The Neglected Chronic Diseases of Adults' (2003) 362 *The Lancet* 903, at 903.

[4] Beaglehole and Yach op cit note 3 at 904; Abdesslam Boutayeb and Saber Boutayeb 'The Burden of Non Communicable Diseases in Developing Countries' 4 *International Journal for Equity in Health* (2005) at 6; Karl-Heinz Wagner and Helmut Brath 'A Global View on the Development of Non Communicable Diseases' (2012) 54 *Preventive Medicine* S38.

[5] Beaglehole and Yach op cit note 3 at 904.

[6] Boutayeb and Boutayeb op cit note 4 at 3.

industrialised countries have come to be imported to developing nations.[7] Such shifts in diet and lifestyle have driven the burgeoning epidemic in low- and middle-income countries.[8]

The most striking feature of this global epidemic is that it is largely preventable.[9] Two thirds of new cases of NCDs are caused by the modifiable risk factors outlined above, that is, risk factors that can be changed.[10] Alcohol consumption and tobacco use contribute significantly to mortality from NCDs, but the consumption of foods with high levels of saturated- and trans-fats, sugar and salt account for 40 percent of all NCD deaths every year.[11] If governments respond to the epidemic through regulating and reducing the consumption of modifiable risk factors, it will be possible to change – and reverse – the course of the global NCD epidemic.[12]

(a) The growing problem of non-communicable diseases in South Africa

While the burden of NCDs in South Africa had initially lagged behind the global trend, the country now has a substantial NCD burden.[13] This delay could be partly attributed to the impact of the HIV/AIDS epidemic on mortality and life expectancy.[14] Yet even at the peak of the HIV epidemic, NCDs were still the second highest cause of death in the country.[15] While the HIV epidemic of the 2000s was rampant and uncontrolled (driven by a government gripped by AIDS denialism) the dramatic change in policy in 2009 has seen the establishment of the largest antiretroviral (ARV) therapy programme in the world.[16] The large numbers of HIV-positive people on ARVs has changed HIV from a fatal disease to a chronic one.[17]

This change has had an enormous impact on the health outcomes and healthcare systems in the country, and the landscape of South African health has been gradually transitioning.[18] Morbidity and mortality amongst South Africans has shifted from being predominantly defined by tuberculosis and HIV to a convergence of four disease burdens of varying severity.[19] As a result, the healthcare system is facing a quadruple burden of disease that places the country – and particularly its healthcare system in a precarious position.[20] The

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[7] Beaglehole and Yach op cit note 3 at 903; Wagner and Brath op cit note 4 at S39.
[8] Beaglehole and Yach op cit note 3 at 903.
[9] Beaglehole and Yach op cit note 3 at 905; Wagner and Brath op cit note 4 at S40.
[10] Michelle Schneider, Debbie Bradshaw, Krisela Steyn et al 'Poverty and Non-Communicable Diseases in South Africa' (2009) 37 *Scandinavian Journal of Public Health* 176 at 178; Wagner and Brath op cit note 4 at S40.
[11] Wagner and Brath op cit note 4 at S39.
[12] Beaglehole and Yach op cit note 3 at 903; Lawrence Gostin 'Law as a Tool to Facilitate Healthier Lifestyles and Prevent Obesity' (2007) 297 *JAMA* 87 at 88; Bongani M Mayosi, Alan J Flisher, Umesh G Lalloo et al 'The Burden of Non-Communicable Diseases in South Africa' 374 *Lancet* (2009) 934 at 942; Bongani M Mayosi, Joy E. Lawn, Ashley van Niekerk et al 'Health in South Africa: Changes and Challenges since 2009' (2012) 380 *Lancet* 2029 at 2040..
[13] Mayosi et al, *Burden* op cit note 12 at 2.
[14] Victoria Pillay-van Wyk, William Msemburi, Ria Laubscher et al 'Mortality Trends and Differentials in South Africa from 1997 to 2012: Second National Burden of Disease Study' (2016) 4 *Lancet Global Health* e642 at e646.
[15] Ibid.
[16] Mayosi et al, *Burden* op cit note 12 at 2.
[17] Ibid.
[18] Ibid.
[19] Pillay-van Wyk et al op cit note 14 at e643..
[20] Ibid.

nature of the NCD epidemic has also meant that present policies and action will determine future health outcomes and disease burdens.[21]

(b) Causes of the NCD epidemic in South Africa

Though non-communicable diseases have traditionally been viewed as a result of individual behaviours, it is becoming more apparent that societal structures – and corporate actors – play a major role in the growing NCD epidemic, both in South Africa[22] and globally.[23] Through individual choices regarding the consumption of risk factors, globalisation has resulted in changing lifestyles and diets,[24] and seen the proliferation and normalisation of unhealthy commodities.[25] As transnational corporations and manufacturers move into new markets, particularly low- and middle-income countries, they pursue aggressive measures to increase the availability, acceptability and accessibility of their products.[26] Many corporate actors pursue strategies to actively undermine public health efforts[27] aimed at ameliorating the harms caused by their products in order to protect profits.[28] Though this phenomenon has been well documented and exposed in relation to the tobacco and alcohol industries, there has been less focus on industries related to ultra-processed, unhealthy foods and sugar-laden beverages.[29]

II. POLICY AND LEGAL RESPONSES TO THE NCD EPIDEMIC

The law is particularly well-placed to address non-communicable diseases – perhaps more so than other health concerns. Legislative change can provide effective mechanisms to influence and mandate behaviours at a population level, and many modifiable risk factors of NCDs are

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[21] Schneider et al op cit note 10 at 180.

[22] Peter Delobelle, David Sanders, Thandi Puoane et al 'Reducing the Role of the Food, Tobacco, and Alcohol Industries in Noncommunicable Disease Risk in South Africa' (2016) 43 *Health Education & Behavior* 70S at 72S; Ehimario U. Igumbor, David Sanders, Thandi R. Puoane et al '"Big Food," the Consumer Food Environment, Health, and the Policy Response in South Africa' (2012) 9 *PLOS Medicine* e1001253.

[23] Gostin op cit note 12 at 87; Roger Magnusson and David Patterson 'The Role of Law and Governance Reform in the Global Response to Non-Communicable Diseases' (2014) 10 *Globalization and Health* 44 at 45; Rob Moodie, David Stuckler, Carlos Monteiro et al 'Profits and Pandemics: Prevention of Harmful Effects of Tobacco, Alcohol, and Ultra-Processed Food and Drink Industries' (2013) 381 *Lancet* 670 at 671; David Stuckler, Martin McKee, Shah Ebrahim, et al 'Manufacturing Epidemics: The Role of Global Producers in Increased Consumption of Unhealthy Commodities Including Processed Foods, Alcohol, and Tobacco' (2012) 9 *PLoS Medicine* e1001235.

[24] This movement away from traditional diets to a "western diet" (including the increased consumption of processed foods high in sugar, salt and fats) prevalent in low- and middle-income countries resulting from globalisation, has been termed the 'nutrition transition'. See Barry M Popkin and Penny Gordon-Larsen 'The Nutrition Transition: Worldwide Obesity Dynamics and Their Determinants' 28 *International Journal of Obesity* (2004) S2 at S3; Mark Spires, Peter Delobelle, David Sanders et al 'Diet-Related Non-Communicable Diseases in South Africa: Determinants and Policy Responses' (2016) *South African Health Review* 35 at 37.

[25] Moodie et al op cit note 23 at 671; Stuckler et al op cit note 23.

[26] Delobelle et al op cit note 22; Igumbor et al op cit note 22.

[27] Chris Bateman 'Motsoaledi Declares War on Disease-Causing Products' (2011) 101 *South African Medical Journal* 503 at 503.

[28] Moodie et al op cit note 23 at 671.

[29] Kelly D. Brownell and Kenneth E. Warner 'The Perils of Ignoring History: Big Tobacco Played Dirty and Millions Died. How Similar Is Big Food?' (2009) 87 *Milbank Quarterly* 259 at 262; Anita George 'Not so Sweet Refrain: Sugar-Sweetened Beverage Taxes, Industry Opposition and Harnessing the Lessons Learned from Tobacco Control Legal Challenges' (2018) *Health Economics, Policy and Law* 1 at 5; Lee Munger 'Is Ronald McDonald the Next Joe Camel-Regulating Fast Food Advertisements Targeting Children in Light of the American Overweight and Obesity Epidemic' (2003) 3 *Conn. Pub. Int. LJ* 456 at 460.

already subject to government regulation.[30] In fact, the most cost-effective measures to prevent NCDs are reliant on changing and enforcing laws and regulations.[31] The priority actions identified by the World Health Organisation (WHO), following the United Nations General Assembly high-level meeting on NCDs, are largely legal and regulatory interventions.[32] For example, the WHO's Global Action Plan 2013-2020 (the GAP) contains sixteen cost-effective interventions aimed at the prevention and control of NCDs, which include regulatory and fiscal interventions to address the modifiable risk factors and underlying determinants of NCDs. Specifically, the GAP focusses on interventions beyond those aimed at strengthening health systems and focusses on cross-sectoral prevention efforts.

The breadth of regulatory mechanisms identified is vast: from now common practices of increasing taxation on tobacco and alcohol, advertising restrictions, and mandatory health warnings, to more novel measures such as placing outright limits on salt content and providing local government with a legal mandate to take steps to improve diet and exercise.[33] The cost and efficacy of each of these measures varies radically, however, and their impact is dependent on the drivers of risk factors and the regulatory system at a local level. [34]

The WHO has compiled a set of regulatory 'best buys' to reduce the prevalence and impact of NCDs. These are evidenced-based interventions identified as feasible in low- and middle-income countries (LMICs) particularly, where resources to combat NCDs may be limited.[35] The WHO's list suggests a number of interventions targeting tobacco and alcohol, including increased taxation, bans on smoking in public areas, and restrictions on advertising for both alcohol and tobacco.[36] Strikingly, the measures suggested for diet and exercise are limited to replacing trans-fats, reducing salt content, and running public awareness campaigns.[37] Issues around food are, admittedly, distinctly more complex than the regulation of tobacco and alcohol.[38] While alcohol and tobacco are harmful to health in any quantity, and their consumption carries little benefit to the consumer, food is necessary for survival.[39] As a consequence, outright bans and restrictions which have been successful in curbing tobacco use, for instance, are not always possible in the case of unhealthy diet.[40]

The number and scope of existing evidence-based interventions across the world demonstrate the vast array of legal mechanisms available to help make unhealthy foods less accessible, affordable and acceptable as well as address obesenogenic food environments (see

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[30] Gostin op cit note 12 at 88; Magnusson and Patterson op cit note 23 at 44.
[31] Roger Magnusson and David Patterson 'The Role of Law in the Global Response to NCDs' (2011) 378 *Lancet* 859 at 860; Magnusson and Patterson op cit note 23 at 44.
[32] Magnusson and Patterson op cit note 31 at 861.
[33] Ibid.
[34] Ibid.
[35] World Health Organisation and World Economic Forum 'From Burden to "Best Buys": Reducing the Economic Impact of Non-Communicable Diseases in Low-and Middle-Income Countries' (2011) available at http://www.who.int/nmh/publications/best_buys_summary.pdf?ua=1, accessed 22 November 2017.
[36] Ibid.
[37] Ibid.
[38] Derek Yach, Corinna Hawkes, JoAnne Epping-Jordan and Sarah Galbraith 'The World Health Organization's Framework Convention on Tobacco Control: Implications for Global Epidemics of Food-Related Deaths and Disease' (2003) 24 *Journal of Public Health Policy* 274 at 276.
[39] Ibid.
[40] Brownell and Warner op cit note 29 at 290; Yach et al supra note 38 at 278.

Table 1).[41] However, the approach undertaken will need to be adapted in line with the particularities of different countries, informed by the specific nature and causes of NCDs and the existing legal frameworks in each.

Table 1: Legal Interventions to Prevent and Control NCDs

<table>
<tr><th>Domain</th><th>Goal</th><th>Intervention</th><th>Example</th></tr>
<tr><td rowspan="7">Healthy Lifestyles</td><td rowspan="7">Optimal Nutrition</td><td>Agricultural Production</td><td>Food and agricultural policies, economic incentives to produce healthier foods</td></tr>
<tr><td>Food Manufacturing, processing, and distribution</td><td>Regulation of food manufacturers and retailers</td></tr>
<tr><td>Disincentives for buying and selling unhealthy food</td><td>Fat Taxes</td></tr>
<tr><td>Marketing unhealthy foods</td><td>Restrictions on marketing to children</td></tr>
<tr><td>Nutritional information disclosure and education</td><td>Providing government nutritional guidelines, improving package labelling, menu labelling</td></tr>
<tr><td>Direct Regulation</td><td>Banning unhealthy ingredients (such as trans-fats)</td></tr>
<tr><td>Public-private partnership</td><td>Voluntary targets for nutritional values</td></tr>
<tr><td rowspan="3">Healthy places</td><td rowspan="3">Nutritious dietary options in neighbourhoods, schools and workplaces</td><td>Access to affordable, healthy foods</td><td>Mobile farmers markets, zoning of unhealthy fast-food restaurants</td></tr>
<tr><td>Healthy foods in schools, workplaces etc</td><td>Soda bans in school vending machines, nutritional audits of cafeterias, healthy food procurement policies</td></tr>
<tr><td>School / childcare curricula and programs</td><td>Body mass index surveillance, nutrition education</td></tr>
<tr><td rowspan="4">Healthy Societies</td><td>Social Justice</td><td>Antidiscrimination laws</td><td>Proscribing health status discrimination</td></tr>
<tr><td rowspan="3">Access to services</td><td>Services to support life functions of ill individuals</td><td>At home support systems</td></tr>
<tr><td>Encouraging prevention and treatment</td><td>Metabolic screening, counselling</td></tr>
<tr><td>Monitoring disease in the community</td><td>Surveillance through BMI reporting</td></tr>
</table>

Source: Adapted from Gostin (2015)[42]

Along with the introduction of new regulatory measures, it is also possible to use existing legal mechanisms to both prevent NCDs and recoup the costs associated with their increasing prevalence.[43] Taxation and labelling laws are already employed to varying degrees in many countries, including South Africa. Taxation affords the government a way to dis-incentivise the purchase of harmful products and provides potential funding for other activities aimed at prevention. Beyond this, initiatives such as retooling regulatory schemes for land use, zoning and planning approvals can allow cities to reshape environments in ways that limit access to harmful products like tobacco, alcohol and fast-food, while making healthy options

[41] Magnusson and Patterson op cit note 23 at 44; Yach et al op cit note 12 at 2620.
[42] Lawrence O. Gostin *Global Health Law* (2015) at 396–7.
[43] Gostin op cit note 12 at 89.

more accessible.[44] When it comes to attributing responsibility for the increased prevalence of NCDs, some success has been found in other countries through the use of tort law or delictual claims to hold tobacco companies to account. Thus far, however, there has been little success in the use of claims to curb other risk factors, particularly food, but this could change as the science becomes more definitive.[45] There have been few successful class actions in South Africa, yet this mechanism may still offer potential avenues in the future.

III. REGULATION OF RISK FACTORS IN SOUTH AFRICA

Historically, the South African government began regulating risk factors well before the advent of democracy in 1994, through mechanisms such as excise taxes imposed on alcohol and tobacco – although these did not explicitly aim to achieve a public health objective.[46] Shortly after the end of apartheid, the new government began to make moves towards regulating tobacco and alcohol for public health reasons. At the time tobacco control legislation was first being considered, South Africa had one of the highest smoking rates in the world.[47] This provided the political will and impetus needed for the government to pass what was, at the time, among the world's most progressive and comprehensive tobacco control legislation.[48] This action ultimately led to a significant reduction in smoking rates.[49]

Stronger alcohol regulation was considered in 1997, around the same time as initial tobacco control measures, and encountered opposition from the alcohol industry.[50] The then Minister of Health advocated for limiting alcohol advertising, regulating alcohol sales and increasing excise taxes. Only the latter measure found support from other departments, including the National Treasury. The alcohol industry successfully lobbied for the self-regulation of advertising and offered to place health warnings voluntarily, thus avoiding greater regulation from government.

The issue of NCDs has undergone something of a renaissance since the Department of Health took on the issue of non-communicable diseases as a priority – a campaign spearheaded by the former Minister Aaron Motsoaledi (served 2009-2019).[51] In 2011, the Department convened the first South African Summit on the Prevention and Control of NCDs which led to

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[44] Marice Ashe, David Jernigan, Randolph Kline et al 'Land Use Planning and the Control of Alcohol, Tobacco, Firearms, and Fast Food Restaurants' (2003) 93 *American Journal of Public Health* 1404 at 1405; Gostin op cit note 12 at 89.
[45] Gostin op cit note 12 at 89.
[46] Charles Parry 'Alcohol Policy in South Africa: A Review of Policy Development Processes between 1994 and 2009' (2010) 105 *Addiction* 1340 at 1342.
[47] Bateman op cit note 30 at 503; Mayosi et al. op cit note 12 at 936.
[48] Tobacco Control Act 83 of 1993.
[49] Initial tobacco control legislation mandated health warnings on packages, banned indoor smoking, and restricted almost all advertising, sponsorship and promotions except for point-of-sale advertising. See Bateman, supra note 30, at 503.
[50] Parry op cit note 54 at 1343.
[51] Bateman op cit note 30 at 503.

the adoption of a declaration that set out a number of targets[52] for prevention and control, and formulated an overall strategic vision for NCD control in South Africa (the Declaration).[53] Following this, the Department published a five-year strategic plan on NCD prevention and control which outlined an inter-sectoral approach and set targets for the year 2017.[54] The Department later published a Health Promotion Strategy,[55] which sought to address health comprehensively by tackling each of the epidemics that together form South Africa's quadruple burden of disease.[56] The government has now implemented a number of measures to address modifiable risk factors, including regulatory interventions.

From a legislative perspective, there are now regulatory measures in operation which aim to reduce the amount of salt in key food items,[57] eliminate trans-fats from foodstuffs,[58] and impose labelling and disclosure requirements that are updated periodically.[59] Table 2 outlines the extent to which South Africa has implemented the policy options recommended by the Global Action Plan on the prevention and control of NCDs.

Table 2: The implementation of Policy options for member states under Global Action Plan for the prevention and control of NCDs 2013-2020 in South Africa

Policy Objective	Text under GAP	Implementation in South Africa
Restrictions on marketing to children	Implement WHO's set of recommendations on the marketing of foods and non-alcoholic beverages to children, including mechanisms for monitoring.	The voluntary code on marketing of unhealthy commodities to children under the Advertising Review Board *Guideline 14 on marketing to children under draft R429.
Sodium Reduction	Reduce the level of salt/sodium added to food (prepared or processed)	Sodium Restriction Regulations
Improve access to healthier options	Increase availability, affordability and consumption of fruit and vegetables	VAT exemption on certain essential food stuffs
Reduction of Harmful Fats	Reduce saturated fatty acids in food and replace them with unsaturated fatty acids	
Reduction of Harmful Fats	Replace trans-fats with unsaturated fats	Trans-fats Regulations

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[52] The targets included reducing tobacco, alcohol and salt consumption, improved screening for NCDs and an overarching goal of reducing premature mortality from NCDs by 2020. See Department of Health 'The South African Declaration on the Prevention and Control of Noncommunicable Diseases' (2011) available at http://www.health.uct.ac.za/usr/health/research/groupings/cdia/downloads/SA_NCD_Declaration.pdf, accessed 2 November 2017 at 5-7.
[53] Delobelle et al op cit note 25 at 71S.
[54] Department of Health 'Strategic Plan for the Prevention and Control of Noncommunicable Diseases 2013-17' available at https://www.health-e.org.za/wp-content/uploads/2013/09/NCDs-STRAT-PLAN-CONTENT-8-april-proof.pdf, accessed 10 November 2017.
[55] Department of Health 'The National Health Promotion Policy and Strategy 2015-2019'(2014).
[56] Ibid at 8.
[57] Regulations Relating to the Reduction of Sodium in Certain Foodstuffs and Related Matters: Amendment in GN R989 in *GG40252* of 6 September 2016.
[58] Regulations Relating to Trans-fat in Foodstuffs in GN R127 in *GG34029* of 17 February 2011.
[59] Regulations Relating to the use of Sweeteners in Foodstuffs: Amendment in GN R248 in *GG 30722* of 8 February 2008; Regulations Relating to the Labelling and Advertising of Foodstuffs in GN R146 in *GG 32975* of 1 March 2010.

Reduction of Sugar	Reduce the content of free and added sugars in food and non-alcoholic beverages	Health Promotion Levy
Reduce consumption of unhealthy foods and drinks	Limit excess calorie intake, reduce portion size and energy density of foods.	-
Engage with food retailers and caterers	Develop policy measures that engage food retailers and caterers to improve the availability, affordability and acceptability of healthier food products (plant foods, including fruit and vegetables, and products with reduced content of salt/sodium, saturated fatty acids, trans-fatty acids and free sugars).	The Food Law Advisory Group under the Department of Health brings together stakeholders in the food sector to improve the healthfulness of food.
Food provisioning	Promote the provision and availability of healthy food in all public institutions including schools, other educational institutions and the workplace.	National school feeding scheme
Fiscal Policies	Consider economic tools that are justified by evidence, and may include taxes and subsidies, that create incentives for behaviours associated with improved health outcomes, improve the affordability and encourage consumption of healthier food products and discourage the consumption of less healthy options.	VAT Exemptions on essential foods Health Promotion Levy
Food Production	Develop policy measures in cooperation with the agricultural sector to reinforce the measures directed at food processors, retailers, caterers and public institutions, and provide greater opportunities for utilisation of healthy agricultural products and foods.	-
Education	Create health- and nutrition-promoting environments, including through nutrition education, in schools, childcare centres and other educational institutions, workplaces, clinics and hospitals, and other public and private institutions.	School Feeding Scheme
Labelling	(j) Promote nutrition labelling, according but not limited to, international standards, in particular the Codex Alimentarius, for all pre-packaged foods including those for which nutrition or health claims are made.	Voluntary Nutrition Facts Panel on packaged foods Regulations on the application of health claims * The Front of Package Labelling System proposed in Draft 429

There are additional bills under consideration that sought to address NCDs, including proposals to introduce simplified nutrition labelling,[60] and restrict alcohol advertising,[61] though little progress has been made on these since their introduction in 2014 and 2016 respectively. The Department has also announced its intention to strengthen South Africa's

[60] Regulations Relating to the Labelling and Advertising of Foods: Proposed Amendment GNR429 in *GG 37695* of 29 May 2014.
[61] Liquor Amendment Bill (BX-2016).

already progressive anti-tobacco legislation by banning indoor and outdoor smoking areas,[62] and implement new regulations around advertising to children.[63] Beyond this, the Minister also attempted to change the culture of 'Phuza Thursday' ('drinking Thursday') to 'Phila Thursday' ('wellness Thursday'), with adverts and social media campaigns promoting exercise, healthier choices and avoiding alcohol consumption.[64]

(c) Difficulties in implementation of NCD prevention interventions

Despite clear political will and an intense commitment from the Department of Health, greater regulation of NCD risk factors, whether alcohol, tobacco or salt, have all been met with opposition from industry stakeholders, political organisations and even civil society organisations.[65] Though excise taxes on alcohol and tobacco have remained in place, and have been escalated without much difficulty, more recent efforts to introduce stricter controls have faced enormous obstacles.

In 2008, Parliament passed additional tobacco control legislation,[66] but its implementation was held up by extensive opposition from the tobacco industry,[67] which launched litigation around the constitutionality of the legislation.[68] These tactics of obstruction have been successfully employed in many other countries attempting to pass tobacco control measures.[69]

One of the most contentious attempt to regulate risk factors thus far has been the sugary beverages tax announced in February 2016.[70] Initially, the tax was intended to be implemented as an effective 20% tax on sugar-sweetened beverages, similar to the sugar tax adopted in Mexico and the United Kingdom.[71] After extensive pushback from opposition parties, industry

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[62] 'Department of Health Wants to Ban Outdoor, Indoor Smoking Areas' *ENCA* 28 November 2017 available at https://www.enca.com/south-africa/department-of-health-to-ban-outdoor-and-indoor-smoking-areas, accessed 28 November 2017.

[63] Bateman op cit note 30 at 503.

[64] Department of Health 'Phila Campaign Presentation' 30 August 2017, available at http://phila.org.za/wp-content/uploads/2017/10/Phila-Properties-Presentation-2017-08-30-v4-Paddy_GENERIC-1.pptx.pdf, accessed 13 November 2017.

[65] Bateman op cit note 30 at 503; Thalia Holmes, 'Salt Sellers Shaken by Motsoaledi's Rules' *Mail & Guardian Online* 28 November 2017, available at https://mg.co.za/article/2013-04-05-00-salt-sellers-shaken-by-rules/, accessed 28 November 2017.

[66] Tobacco Products Control Amendment Act 63 of 2008.

[67] Delobelle et al op cit note 25 at 72S.

[68] *British American Tobacco South Africa (Pty) Limited v Minister of Health* (GNP) unreported case number 60230/2009 of 19 May 2011 (*BAT I); British American Tobacco South Africa (Pty) Ltd v Minister of Health* (463/2011) [2012] ZASCA 107 (*BAT II*);

[69] Brownell and Warner op cit note 32 at 261.

[70] 'Why sugar tax would be devastating for South Africans' *Health24* 21 January 2016 available at http://www.health24.com/Diet-and-nutrition/Healthy-foods/why-a-20-sugar-tax-will-be-devastating-for-south-africans-20160121, accessed 25 February 2019.

[71] Yunus Carrim 'Rates and Monetary Amounts Bill & Sugary Beverages Tax; BEPS Multilateral Instrument: Briefing' (2017), available at https://pmg.org.za/committee-meeting/24430/, accessed 28 November 2017; Arantxa M. Colchero, Barry M. Popkin, Juan A. Rivera et al 'Beverage Purchases from Stores in Mexico under the Excise Tax on Sugar Sweetened Beverages: Observational Study' (2016) 352 *BMJ* h6704.

stakeholders and trade unions, the sugar tax, renamed the Health Promotion Levy (the Levy) was reduced from 20% to an effective 11%.[72]

Although South Africa has now joined other countries that have implemented sugar taxes, such as Denmark and Mexico, it was implemented a year late after significant pushback from the sugar and sugar-sweetened beverage industry.[73]

The public campaign waged by industry was only one aspect of its efforts to combat the implementation of what was ultimately a small and diluted sugar tax.[74] After public consultations concluded, it was revealed that the chair of the Financial Standing Committee, Yunus Carrim, had received threatening phone calls from industry-linked individuals, pressuring him to abandon the Levy.[75] Most concerning were emails from the Coca-Cola Company that outlined a strategy to combat the sugar tax in ways eerily similar to those established in the tobacco industry playbook decades ago.[76] The strategy spoke of the need to create uncertainty about the efficacy of sugar taxes, to emphasise potential adverse economic impacts, and to highlight the steps industry was already taking to mitigate consumption. The emails, along with Coca-Cola's own submissions around the proposed tax, also outlined a range of self-regulation efforts which aimed to stave off government regulation, including changing packaging, reformulating products and actively promoting lower calorie or sugar-free products.[77] In fact, the Coca-Cola Company began implementing these measures before the tax came into effect by reducing the size of a 'buddy bottle' from 500 ml to 440 ml, without changing the price of the drink,[78] and advertising sugar-free variants of their soft drinks.[79] These measures were touted as attempts to both reduce sugar consumption and comply with evidence about the harms of excessive consumption of sugar.[80] It is worth noting, however, that none of these measures were adopted in South Africa until after the Levy was tabled in Parliament, despite the fact that similar measures had been adopted and implemented by the

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[72] Safura Abdool Karim, Petronell Kruger and Karen J Hofman 'Industry Strategies in the Parliamentary Process of Adopting a Sugar-Sweetened Beverage Tax in South Africa: A Systematic Mapping' (2020) 16 *Globalization and Health* 116 at 120.
[73] Ibid.
[74] Abdool Karim, Kruger & Hofman op cit note 80 at 122.
[75] Kerry Cullinan 'Industry threatens MP over sugar tax' *Health-e News* 22 November 2017 available at https://www.health-e.org.za/2017/11/22/industry-threatens-mp-sugar-tax/, accessed 6 December 2017.
[76] The strategy used by the tobacco industry to undermine efforts to regulate tobacco has been defined by researchers as the 'tobacco industry playbook'. The strategy included denying the science, deflecting attention away from tobacco as a cause of illness, marketing to children, extensive lobbying efforts and social responsibility efforts which were either unrelated to tobacco consumption or self-regulation policies to pre-empt more stringent government regulations. See Brownell and Warner op cit note 32 at 290; Munger op cit note 32 at 458.
[77] Abdool Karim, Kruger & Hofman op cit note 80 at 122.
[78] '[LISTEN] Why Coca-Cola's 'buddy' Bottles Are Smaller' *Eyewitness News* 28 November 2017, available at http://ewn.co.za/2017/11/22/listen-why-coca-cola-s-buddy-bottles-are-smaller, accessed 28 November 2017; 'SA Fizzy Drinks Undergo 'Shrinkflation' to Control Sugar Intake' *Radio 702* 28 November 2017, available at http://www.702.co.za/articles/281648/sa-fizzy-drinks-undergo-shrinkflation-to-control-sugar-intake, accessed 28 November 2017.
[79] Coca-Cola Company 'Our Way Forward' 28 November 2017 available at http://www.coca-colacompany.com/way-forward, accessed 28 November 2017; Coca-Cola Company 'Coke's Strategic Evolution Supports World Health Organization's Daily Added Sugar Recommendations' 28 November 2017 available at http://www.coca-colacompany.com/stories/coke_s-strategic-evolution-supports-world-health-organizations-d, accessed 28 November 2017.
[80] Ibid.

Coca-Cola Company in the United Kingdom for years.[81] Coca-Cola had undertaken various measures to reduce sugar in their drinks in both Ireland and the UK after plans for a sugary beverage or soda tax were announced,[82] even as the company continued to insist that a sugar tax would not work in combatting obesity.[83]

IV. THE ROLE OF HUMAN RIGHTS IN THE RESPONSE TO NCDS

Beyond the role of law in the NCD response as providing interventions, human rights (HR) frameworks in particular are well placed to regulate and limit the harmful conduct of both state and third parties.[84] Moreover the content of these rights and the obligations they impose on State actors serve two important functions. The first is that they guide and can compel State action to prevent NCDs. Given the challenges associated with NCD prevention as well as the relative novelty of interventions – human rights can be used as a guide on what action is required from States and provide a yardstick to measure progress. The second is that supportive rights can be used to address one of the central critiques of the NCD prevention movement, that it impinges on individual civil and political rights. Where rights may be invoked to support or promote action against NCDs, this must be factored into balancing and limitations analysis and may serve to justify the limitation of individual rights in service of promoting health objectives.

This has been demonstrated in challenges to tobacco control measures where parties have argued that these policy interventions violate international investment and trade agreements, such as Australia's plain packaging laws[85] and Uruguay's larger health warnings.[86] While public health measures have thus far withstood these challenges under international law, future measures need to be implemented with this in mind. [87]

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[81] Ivana Kottasova 'Soda Wars: The UK's Tax on Sugary Drinks Is Working' *CNN Money* (2017) available at http://money.cnn.com/2017/03/09/news/economy/soda-tax-uk-sugar-revenue/index.html, accessed 6 December 2017; Coca-Cola Company, 'Choice and Information: Delivering on Our Commitments' 2015 available at http://www.coca-cola.co.uk/content/dam/journey/gb/en/hidden/PDFs/coca-cola-choice-and-information-report.pdf, accessed 28 November 2017.

[82] 'Coca-Cola Revamps Coke Zero Under Pressure to Perk Up Soda' *Hospitality Ireland* 18 October 2017 available at https://www.hospitalityireland.com/coca-cola-revamps-coke-zero-pressure-perk-soda-2/46855 accessed 18 October 2017; Kottasova, supra note 95.

[83] Press Association 'Sugar Tax Is Arbitrary and Unfair, Says Pressure Group' *The Guardian* (2016) available at https://www.theguardian.com/society/2016/may/29/sugar-tax-is-arbitrary-and-unfair-says-pressure-group, accessed 6 December 2017; 'Sugar tax is arbitrary and unfair, says pressure group' *Guardian* 29 May 2016, available at https://www.theguardian.com/society/2016/may/29/sugar-tax-is-arbitrary-and-unfair-says-pressure-group accessed 6 December 2017.

[84] Jonathan Liberman 'Making Effective Use of the Law in the Global Governance of NCD Prevention' in Tania Voon, Andrew Mitchell and Jonathan Liberman Liberman (eds.) *Regulating Tobacco, Alcohol and Unhealthy Foods: The Legal Issues* (2014) 12-36 at 15.

[85] *Philip Morris Asia Limited v. The Commonwealth of Australia*, UNCITRAL, PCA Case No. 2012-12.

[86] *Philip Morris Brands Sàrl, Philip Morris Products S.A. and Abal Hermanos S.A. v. Oriental Republic of Uruguay*, ICSID Case No. ARB/10/7 (formerly FTR Holding SA, Philip Morris Products S.A. and Abal Hermanos S.A. v. Oriental Republic of Uruguay).

[87] Liberman op cit 84 at 16.

V. THE NEED FOR A CONSTITUTIONAL RIGHTS-BASED APPROACH

The sugar industry's concerted opposition to the Levy (and to the principle of a sugar tax more generally), as well as the tactics employed by tobacco and alcohol industries against government regulation, all offer insights into the kind of opposition that steps to regulate diet-related risk factors will likely face.[88] Even after the passage of regulations and legislation around tobacco, for instance, the industry has continued to challenge the legality of measures through international trade laws,[89] as well as in the domestic courts of many countries, including South Africa.[90] While public health arguments were successful in protecting Uruguay's tobacco control laws, laws aimed at regulating other NCD risk factors may be subjected to the same litigation and will need an equally strong legal basis to shield them from industry attack. In addition, effective regulations targeting the drivers of NCD risk factors require a coordinated, multi-sectoral response that cannot be adopted piecemeal.[91] While the Department of Health has been spearheading the fight against NCDs and has created comprehensive policies, the implementation has been sporadic and unclear, as outlined above. This dissertation will attempt to craft a constitutional obligation and framework for the regulation of risk factors as a solution that can address the two major issues facing the regulation of risk factors in South Africa. The constitutional imperative to regulate risk factors can serve a number of purposes. In particular, it may bolster regulations against legal attack from industry. Additionally, it can provide a benchmark for the required response by creating a way to measure implementation and assess whether government is meeting its constitutional obligations.

VI. RESEARCH QUESTION, AIM AND OBJECTIVE

The aim of the thesis is to analyse how the right to access sufficient food and the right to access healthcare can be used to prevent diet-related, non-communicable diseases by creating an obligation on government to introduce interventions and assess whether these interventions are constitutional in their limitation of other rights. The primary research question of this thesis is:

How can constitutional rights be used to support and promote the prevention and control of NCDs in South Africa?

To answer this question, this thesis will investigate three sub-questions, namely:

1. How can the right to food and health be used to support NCD prevention?
2. What are the obligations these different rights impose on government?
3. How should conflicts between these socio-economic rights and other rights that may be infringed by NCD prevention measures be managed?

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[88] Abdool Karim, Kruger & Hofman op cit note 80 at 123; Kruger et al op cit note 84.

[89] *Philip Morris Brand Sàrl* supra note85; *Philip Morris Asia Limited* supra note .

[90] *BAT II* supra note 68 above.

[91] Beaglehole and Yach op cit note 3 at 907; Jan De Maeseneer, Chris van Weel, David Egilman, et al 'Tackling NCDs: A Different Approach Is Needed – Authors' Reply' (2012) 379 *Lancet* 1873 at 1874; Martin McKee and David Stuckler 'Revisiting the Corporate and Commercial Determinants of Health' (2018) 108 *American Journal of Public Health* 1167 at 1169; Neil Pearce, Shah Ebrahim, Martin McKee, et al 'Global Prevention and Control of NCDs: Limitations of the Standard Approach' (2015) 36 *Journal of Public Health Policy* 408 at 420.

VII. RESEARCH DESIGN AND METHODS

The methods adopted in this thesis include secondary data analysis, desk-based research and review. The analytical approach is doctrinal, the method typically utilised for legal research of this nature. The chapters involve primarily theoretical research. The focal point is constitutional interpretation informed by a range of primary sources, including international law and approaches adopted in jurisdictions, as well as the case law and legislation in South Africa relating to food and regulation thereof. Secondary sources considered include legal scholarship alongside research on the NCD epidemic and the effectiveness of various interventions. The data analysed has been gathered from policy papers, case law, legislation, foreign law, reports, journal articles, legal commentaries, research papers, newspaper articles, statistical data, books and treaties and international instruments. Given the interdisciplinary nature of the research question, both legal and non-legal sources are used.

VIII. THE IMPACT OF COVID-19 ON THIS THESIS

Though the SARS-CoV-2 pandemic (COVID-19) had not yet begun when this research was initiated, its impact on the law and jurisprudence related to public health cannot be understated. The epidemic and associated jurisprudence are particularly relevant to NCD prevention, as many of the measures adopted were novel and non-biomedical interventions. Indeed, the initial pandemic response was characterised by the lack of pharmaceutical interventions to prevent or treat COVID-19, and most of the interventions adopted were driven through regulations and laws. The COVID-19 response also resulted in the limitation of a number of rights for public health objectives in unprecedented ways, and there was correspondingly extensive litigation regarding the response, some of which remains pending. For these reasons, COVID-19-related jurisprudence and literature is heavily relied upon throughout this thesis, but especially in the following chapters: in Chapter 3 to inform the content of the right to health; in Chapter 6 to outline the relationship between public health and HR; and in Chapter 7 to understand the considerations in limiting constitutional rights through the implementation of novel public health interventions. The epidemiological and legal landscapes of COVID-19 are still evolving, and thus it is extremely difficult to encapsulate each new development. This thesis addresses the issues related to COVID-19 jurisprudence as it stood at the time that writing was completed in October 2021.

IX. STRUCTURE OF THE THESIS

This thesis will develop and apply a HR-based approach to NCD prevention, focusing specifically on population-level legal interventions. It is structured according to three main components.

The first component develops the HR-based approach. This development will occur over Chapters 2-4 and will investigate the elements of a HR-based approach to NCDs that are supportive of prevention measures. Chapter 2 provides an overview of the literature on HR and NCDs, identifying the particular elements that comprise a HR-based approach. The next chapters aim to develop content within specific rights that would encompass NCD prevention, namely the right to health and the right to food – the two rights most often invoked in the HR-based literature on NCDs. This thesis will investigate and develop content within the South African right to health in Chapter 3 and the right to food in Chapter 4, with a view to developing

and exploring how each of these rights can be used to support NCD prevention efforts. In respect of the content of these rights, it is acknowledged that many interventions related to NCD prevention are not bio-medical or pharmaceutical interventions but often sit outside the healthcare sector, and thus the application of section 27 must be developed to consider the role and content of the rights to access to food and healthcare outside the healthcare system. This will provide the foundation for an HR-based approach to NCD prevention in the South African context.

The second component of this thesis focuses on the application of the HR-based approach by identifying and concretising obligations related to NCD prevention. This consists of both identifying obligations and delineating the limits of these obligations. Chapter 5 seeks to concretise obligations and entitlements under HR-based approach to NCDs developed in the preceding chapters and consider how various NCD prevention interventions may implicate various HR and interface with these obligations. This proceeds from an understanding that a HR-based approach to NCD prevention does not only conceive of rights as enablers, supportive of public health interventions, but also as potential impediments where proposed interventions limit individual rights.

The third component builds on this conceptualisation and considers who to resolve tensions between competing rights implicated in NCD prevention interventions. This is particularly important in light of the invocation of competing rights in opposition to NCD prevention measures. Consequently, Chapters 6 and 7 will consider how this conflict between the rights that support NCD prevention and those that are limited by interventions ought to be resolved. Chapter 6 will consider whether NCD prevention efforts may justifiably infringe individual rights and explore in detail how to reconcile instances in which multiple rights are implicated in the adoption and implementation of public health interventions. Chapter 7 will explore the application of a section 36 limitations analysis to public health interventions, utilising case law to understand the application of this test to justify the limitation of rights in for novel NCD prevention interventions.

Chapter 8 will conclude with recommendations for how South Africa can move forward with a HR-based approach to its NCD prevention efforts.

CHAPTER 2
A HUMAN RIGHTS-BASED APPROACH TO PREVENTION OF DIET- AND OBESITY-RELATED NON-COMMUNICABLE DISEASES

I. INTRODUCTION

The application of a HR framework to the diet-related NCD epidemic is a developing arena and consequently, there is a need for a comprehensive consideration of rights in the context . Whilst there is extensive literature on the utilisation of HR in responses to the HIV epidemic and in efforts to buttress tobacco control globally, the terrain around the prevention of food-related NCDs and obesity[92] is not as well explored.[93] This underdevelopment of the field is partly attributable to the factors that have led to late recognition of the need to address the NCD epidemic as a public health crisis.[94] Despite the high burden of NCDs globally, there is a continuing perception that these diseases are attributable to individualistic factors as domains where states should not interfere.[95] This perception has even seeped into the language utilised in HR instruments. In General Comment 14,[96] for example, the Committee on Economic, Social and Cultural Rights (CESCR) discusses the limits of the right to health and specifically excludes adverse health outcomes resulting from, inter alia, an individual's 'unhealthy or risky lifestyle' from the ambit of the right to health, stating:

> 'The notion of 'the highest attainable standard of health' in article 12.1 takes into account both the individual's biological and socio-economic preconditions and a State's available resources. There are a number of aspects which cannot be addressed solely within the relationship between States and individuals; in particular, good health cannot be ensured by a State, nor can States provide protection against every possible cause of human ill health. Thus, genetic factors, individual susceptibility to ill health and *the adoption of unhealthy or risky lifestyles may play an important role with respect to an individual's health*. Consequently, the right to health must be understood as a right to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health.'[97]

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[92] Throughout this thesis, the term "NCDs" will be used to refer specifically to diet-related NCDs and obesity as a risk factor for these diseases.

[93] Laura Ferguson, Danial Tarantola, Michael Hoffmann et al 'Non-Communicable Diseases and Human Rights: Global Synergies, Gaps and Opportunities' (2017) 12 *Global Public Health* 1200 at 1201; Emma Gorman and Elizabeth Handsley 'International Human Rights Law and the Prevention of Childhood Obesity' (2017) 23 *Australian Journal of Human Rights* 390 at 391.

[94] Ferguson et al op cit note 102 at 1202; Benjamin Mason-Meier and Larisa M Mori 'The Highest Attainable Standard: Advancing a Collective Human Right to Public Health' (2005) 37 *Columbia Human Rights Law Review* 101 at 105.

[95] Ferguson et al op cit note 102 at 1202 where, explaining the reasons for non-recognition or delayed recognition of NCDs, they note: 'Factors contributing to this late recognition include the perception of NCDs as dependent on individual and societal factors beyond the realm of state control, the lack of a "magic bullet" such as a vaccine to prevent them, and poor documentation and under-appreciation of their epidemiological, demographic and economic impacts'.

[96] Committee on Economic, Social and Cultural Rights 'General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12)' E/C.12/2000/4 22nd Session of the Committee on Economic, Social and Cultural Rights, (11 August 2000) available at https://www.refworld.org/pdfid/4538838d0.pdf, accessed 2 July 2021).

[97] Ibid at para 9 (emphasis added).

The framing of NCDs as lifestyle diseases or as attributable to individual behaviours arose as a dominant narrative which has served to move the risk factors contributing to NCDs beyond the domain of legitimate state regulation.[98] Over the past few decades, however, there has been a growing recognition that while NCDs are partly influenced by lifestyle choices, individual behaviours and genetics, there are broader modifiable risk factors and obesogenic environments which significantly contribute to the burden of NCDs.[99] While there are a multiplicity of factors influencing NCDs, there is consensus in the public health community that the burden of disease can be prevented if the underlying determinants of built environment and nutrition are targeted through effective state action and regulation.[100]

At present NCDs and their risk factors are not given explicit recognition or directly targeted in any HR treaties.[101] Yet in comments and soft law instruments, there is growing recognition of the relationship between NCDs and HR.[102] Where recognised, albeit in a limited manner, the HR-based approach to NCDs at the international level has broadly been couched in the right to health. The UN General Assembly's (UNGA) Political Declaration on the Prevention and Control of Non-Communicable Diseases (the 2012 Declaration),[103] for instance, recognised the need for action at global, regional and national levels to prevent and control NCDs, and explicitly linked this need for action to the reaffirmation of the right of everyone to the highest standard of health.[104] Specifically, the 2012 Declaration recognised an 'urgent need for greater measures …to prevent and control noncommunicable diseases …to contribute to the full realization of the right of everyone to the highest attainable standard of physical and mental health.'[105] The 2012 Declaration also recognised the need to address the underlying determinants of NCDs, recommending the pursuit of 'policies that support the production and manufacture of, and facilitate access to, foods that contribute to healthy diet', and expanding the 'availability of safe environments in public parks and recreational spaces to encourage physical activity'.[106] However, significant portions of the 2012 Declaration continued to call for the strengthening of healthcare and reporting systems related to treating and diagnosing NCDs. In the 2030 Agenda for Sustainable Development, the international community committed to 'reduce by one-third premature mortality from noncommunicable diseases through prevention and treatment',[107] once again emphasising treatment and diagnosis

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[98] Ferguson et al op cit note 102 at 1204; Signild Vallgårda 'Why the Concept "Lifestyle Diseases" Should Be Avoided' (2011) 39 *Scandinavian Journal of Public Health* 773 at 774.
[99] Antonio De Lorenzo, Lorenzo Romano, Laura Di Renzo et al 'Obesity: A Preventable, Treatable, but Relapsing Disease' (2020) 71 *Nutrition* 110615; Garry Egger and Boyd Swinburn 'An "Ecological" Approach to the Obesity Pandemic' (1997) 315 *BMJ* 477 at 479; Boyd Swinburn and Garry Egger 'Preventive Strategies against Weight Gain and Obesity' (20020) 3 *Obesity Reviews* 289 at 290.
[100] Gorman and Handsley op cit note 102 at 391; Swinburn and Egger op cit note 108 at 291.
[101] While unhealthy diet is not recognised, tobacco is encompassed for example under the Framework Convention on Tobacco Control, entered into force on 27 February 2005 (the FCTC).
[102] Ferguson et al op cit note 102 at 1217.
[103] Political Declaration on the Prevention and Control of Non-Communicable Diseases (United Nations, 2012) available at http://www.who.int/nmh/events/un_ncd_summit2011/political_declaration_en.pdf.
[104] Ibid at 2.
[105] Ibid at 7.
[106] Ibid.
[107] Target 3.4 of the Sustainable Development Goals (2015) available at https://sdgs.un.org/goals, accessed 26 October 2021.

as the dominant pathway to addressing the epidemic over a focus on the underlying determinants of the diseases.

Human rights and health do share a relationship that sees them connected and interacting in a multitude of ways – particularly when it comes to public health measures. It is recognised under General Comment 14 that, at a minimum, states bear certain obligations under the right to health, including: (1) an obligation to respect which prevents states from interfering with their citizen's enjoyment of the right to health; (2) an obligation to protect which requires states to adopt measures that prevent others from interfering with the right; (3) an obligation to fulfil the right to health which requires states to 'progressively adopt appropriate legislative, administrative, budgetary, judicial, and other measures towards the full realization of the right to health'.[108] These obligations and the corresponding measures could encompass many of the preventative measures for NCDs discussed in Chapter 1.

Yet, concretising the full extent of HR obligations in relation to NCD prevention involves more complex preventative action than simply strengthening healthcare systems for purposes of improving treatment and diagnosis. The underlying determinants and risk factors for NCDs may fall within the ambit of the right to health or within that of other socio-economic rights which have been recognised as a part of the right to health. To this end, the CESCR expressly recognised the role of these underlying determinants in realising the right to health, stating:

> [T]he drafting history and the express wording of article 12.2 acknowledge that the right to health embraces a wide range of socio-economic factors that promote conditions in which people can lead a healthy life, and extends to the underlying determinants of health, such as food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions, and a healthy environment.[109]

This determinants framing of the right to health was expanded through the development of rights-based approaches to HIV which framed the realisation of the right to health as an antecedent to the fulfilment of other HR.[110] Since then an HR-based approach to global health more broadly has been adopted and operationalised through, inter alia, developing the right to health to encompass the social determinants of health, to include recognition of the influence that education, housing and equality may have on health outcomes.[111] This represents a departure from some of the traditional conceptualisations of the right to health under international instruments which have defined the right largely through the lens of the provision of, and access to, curative and preventative healthcare.[112] The inclusion of the underlying determinants of health provides a pathway for addressing – and more specifically preventing –

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[108] General Comment 14 at para 33.
[109] General Comment 14 at para 4.
[110] Jonathan M Mann, Lawrence Gostin, Sofia Gruskin et al 'Health and Human Rights' (1994) 1 *Health and Human Rights* 6—23 at 12.
[111] General Comment 14 at para 4 states that the right to health is 'an inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health'. See also Lawrence O. Gostin, Benjamin M. Meier, Rebekah Thomas et al '70 Years of Human Rights in Global Health: Drawing on a Contentious Past to Secure a Hopeful Future' (2018) 392 *Lancet* 2731 at 2733.
[112] Ibid at 2733.

NCDs, providing scope to frame these diseases through a rights-based approach, despite not being explicitly discussed in any HR treaty.[113]

Notwithstanding these developments, however, the application of a HR-based approach to food-related NCDs and obesity remains more complex than in the case of other public health crises because of the way in which these risk factors have come to be integrated in our everyday lives. De Vos et al eloquently outline the numerous sections and factors which need to be addressed in a comprehensive NCD response:

> 'NCDs are linked to the way we eat, the way we exercise, the way we live, and to the accessibility and organisation of care. Effective control of NCDs requires a comprehensive approach. Even more so at a time when 'deep concern about the impact of the financial and economic crisis' pervades the UN. Therefore, NCD targets must explicitly address global and local social determinants. Corporate behaviour, including potentially damaging marketing practices, must be regulated. Equitable access to healthy food, care, and medicines needs public intervention supported by empowering processes in communities.'[114]

In this sense, an effective and comprehensive response to NCDs must address issues spanning a variety of sectors beyond healthcare, including, for instance, agriculture, trade and industry.

An HR-based approach is furthermore required to buttress a myriad of NCD prevention efforts, including ensuring access to food and healthcare services, protecting individual rights from interference from corporations, and limiting the availability of harmful products.[115] Recognising this, Patterson et al propose that a conceptual framework for obesity prevention should encompass a broad array of rights beyond the right to health (Figure 1 below) as a starting point for building an HR-based approach to NCD prevention.[116]

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[113] Global Health and Human Rights 'Background Paper: Attention to Non Communicable Diseases by the United National Human Rights Treaty Bodies, Roles and Responsibilities in Realising Health and Human Rights in the Prevention and Control of Non Communicable Diseases' available at https://uscglobalhealth.files.wordpress.com/2016/06/attention-to-non-communicable-diseases-by-the-united-nations-human-rights-treaty-bodies.pdf, accessed 10 November 2021 at 2.

[114] Pol de Vos, Angelo Stefanini, Wim De Ceukelaire et al 'A Human Right to Health Approach for Non-Communicable Diseases' (2013) 381 *Lancet* 533 at 534.

[115] Ibid.

[116] David Patterson, David, Kent Buse, Roger Magnusson 'Identifying a Human Rights–Based Approach to Obesity for States and Civil Society' (2019) 20 *Obesity Reviews* 45 at 47.

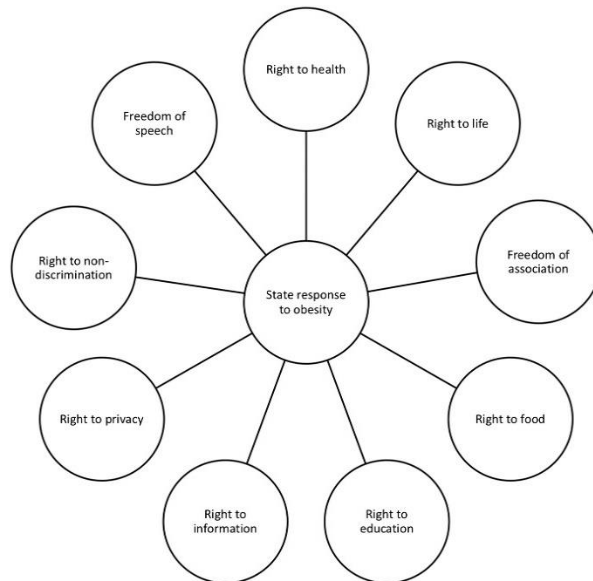

Figure 1: State human rights obligations at the centre of the obesity response (non-exhaustive list) from Patterson et al[117]

The framework outlined in Figure 1 encompasses not only rights that may buttress NCD prevention efforts but also those that could serve to undermine them.[118] Put differently, NCD prevention measures can be supported by the right to health and life, as well as other socio-economic rights such as the right to food or education;[119] yet simultaneously, the implementation of these measures may also infringe or negatively implicate other rights.[120] For example, limiting or prohibiting advertising of unhealthy products to children may assist in protecting health, but such measures also have implications for freedom of speech which need to be weighed and balanced before adoption. In this sense, a comprehensive HR-based approach to NCD prevention must not only be anchored in supportive rights but must also include consideration of rights negatively impacted by the measures.[121] Under the South African Constitution, this would include a limitations analysis under section 36 which is discussed in Chapters 6 and 7.

This tension between individual rights, individual autonomy and health-related rights is an additional complexity within the conceptualisation of a HR-based approach to NCDs. Whilst it may be generally understood that governments have a duty to protect and promote health by taking particular actions and regulating the behaviour of their populations, the extent of this duty has not been defined. In particular, there is a concern that some measures aimed at preventing NCDs may result in discrimination or otherwise limit individual rights or individual

[117] Ibid.
[118] Ibid at 49.
[119] Ibid.
[120] Ibid at 50.
[121] Ibid at 47.

autonomy and freedom of choice.[122] At the same time, it must be recognised that a person's health is influenced by a myriad of underlying determinants, some of which may be partially or entirely outside of their control.[123] In applying an HR-based approach to NCDs, there is a need to balance each of these competing interests and framings of the epidemic and its relationship to rights and public health. This tension will be discussed in detail in Chapter 6.

II. CHARACTERISING THE ROLE OF HUMAN RIGHTS IN NCD RESPONSES

The dominant narratives around the NCD epidemic have characterised it as emanating from individual behaviour, and thus requiring individually focused interventions.[124] As has been discussed extensively in Chapters 1 and 2, however, NCDs are not attributable solely to individual lifestyle choices but are driven by a range of systemic, structural, environmental and social factors.[125] There is in fact now increasing recognition that individual choice has very little to do with the NCD epidemic, and that the epidemic is instead predominantly shaped by underlying structural determinants.[126] This structuralist view, as applied to NCDs by Yang et al, recognises that conditions external to the individual may determine their actions, and societal norms can serve to constrain choice. In this sense, even where individuals have the ability to make choices, these choices occur within the boundaries set by society, government and even private actors.[127]

The focus on individual behaviour that shaped the early NCD response led to an overemphasis on individual interventions and often neglected or opposed the adoption of government-driven interventions such as laws and policies.[128] However, as Yang et al summarise, this conceptualisation has changed significantly and there is now a scientific consensus that structural interventions are a primary mechanism to address the epidemic:

> 'An individualized frame of NCDs urges individuals to cease tobacco use, eat a healthy diet, reduce alcohol consumption, and engage in physical activity. As such, the central responsibility of the government is to engineer incentives and disincentives for certain behaviors through policies such as taxes and create the exchange "markets" within which individuals make decisions to improve their health status. Increasingly, however, calls to incorporate structural factors into the NCDs discourse have emerged.'[129]

While the field of public health has undergone this evolution, there is a need to similarly develop HR thinking around the relationship between NCD prevention efforts and individual rights.

Against the historical backdrop of an emphasis on individual responsibility, NCD prevention efforts have often been framed as incursions on individual autonomy and the

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[122] Helena Nygren-Krug 'A Human Rights-Based Approach to Non-Communicable Diseases' in Andrew Clapham, Mary Robinson, Claire Mahon and Scott Jerbi (eds) *Realizing the Right to Health, Swiss Human Rights Book* (2009) at 263-276 at 271.
[123] Ibid at 272.
[124] Magnusson and Patterson op cit note 31; Pearce et al op cit note 91.
[125] Diem et al op cit note 215 at 10; Pearce et al op cit note 91 at 410; Yang, Mamudu and John op cit note 507 at 71.
[126] Yang, Mamudu and John op cit note 507 at 68.
[127] Ibid.
[128] Ibid.
[129] Ibid.

promotion of a paternalistic, 'nanny state'.[130] This narrative, which portrays the state as seeking to dictate the ways in which individuals live their lives, has been particularly pervasive in neoliberal economics and democracies that place a high value on individual liberties and rights.[131] The 'nanny state' is perceived to be taking away individual choices.[132] It has become increasingly clear that the consumption of unhealthy commodities is not a result of an exercise of free choice but rather a result of particular environmental and social determinants.[133]

In addition, it has become increasingly clear that this supposed deference to freedom of choice by producers of unhealthy commodities is less motivated by concern with individual autonomy per se, and more about allowing the free market to determine and shape these choices over public-health based interventions.[134] Here, HR narratives have been weaponised by industry actors to protect their interests, stave off government regulation and ultimately promote their products at the cost of public health – including undermining NCD prevention efforts.[135] As Moodie puts it, 'Tobacco, alcohol, and diabetes related to being overweight and obesity all have one feature in common. They are each largely driven, and in the case of tobacco completely caused, by powerful commercial interests in the form of transnational corporations'.[136]

In response to these issues around autonomy and supposed paternalism in NCD prevention, Bartlett offers a means to distinguish between justifiable and unjustifiable paternalism in government policy. Paternalistic regulations, he argues, are found in 'governments exercising their power over individuals in order to substitute the preferences of the individual for the preferences of the government".[137] This definition frames paternalism as constituted by instances in which power is exercised by the state over individuals as opposed to corporate actors, and consists of preference substitution and not promotion of the individual's well-being or health. By contrast, where an action serves to the benefit of the individual and does not replace their preferences, it should not be perceived as unjustifiably paternalistic.[138] In this manner, many of the arguments about paternalism levelled at public health interventions may be better framed as health promoting interventions where they do not entirely substitute preferences but create environments where health promoting choices are

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[130] Roger Magnusson 'Case Studies in Nanny State Name-Calling: What Can We Learn?' (2015) 129 *Public Health* 1074 at 1076; Rob Moodie 'NCDs and the Culture Wars: Creating Healthy Policies to Prevent NCDs' in *Dancing in the Rain: Living with NCDS (Noncommunicable Diseases)* (2015) 41 at 49; Christina A. Roberto and Jennifer L. Pomeranz 'Public Health and Legal Arguments in Favor of a Policy to Cap the Portion Sizes of Sugar-Sweetened Beverages' (2015) 105 *American Journal of Public Health* 2183 , at 2188.

[131] Magnusson op cit note 130 at 1074; Moodie op cit note 130 at 49.

[132] Magnusson op cit note 130 at 1075.

[133] Albert Lee 'The Right to Health Promotion: Revisiting the Healthy Settings Approach' *The Healthy Settings Approach in Hong Kong: Sustainable Development for Population Health* (2021) at 166.

[134] Oliver J. Bartlett 'Multinational Food Corporations and the Right to Health: Achieving Accountability through Mandatory Human Rights Due Diligence?' in Amandine Garde, Joshua Curtis and Olivier de Schutter (eds) *Ending Childhood Obesity* (2020); Magnusson op cit note 130 at 1074; Moodie op cit note 130 at 49; Belinda Reeve and Lawrence O. Gostin, '"Big" Food, Tobacco, and Alcohol: Reducing Industry Influence on Noncommunicable Disease Prevention Laws and Policies', 8 *International Journal of Health Policy and Management* (2019) at 450.

[135] Magnusson op cit note 130 at 1078; Moodie op cit note 130 at 46; Reeve and Gostin op cit 134 at 452.

[136] Moodie op cit note 130 at 46.

[137] Oliver J. Bartlett 'Power, Policy Ideas and Paternalism in Non-communicable Disease Prevention' (2018) 24 *European Law Journal* 474 at 12.

[138] Ibid at 13.

more accessible. Even in this conception, however, Bartlett recognises that the infringement of individual rights may nevertheless pose a challenge to these interventions. In response, he contends that in many instances, HR can be better realised through the use of these NCD prevention interventions, stating:

> 'Underlying the argument from proportionality is the assumption that the balance to be struck between the various competing rights must always be struck in favour of regulation that is least restrictive. Individuals have a right to an environment that gives them the opportunity to pursue their highest attainable level of health. However, individuals also have rights to private life, freedom of thought, and freedom of expression, which the substitution of individual preferences for government preferences in lifestyle decision- making could endanger. Thus, the objection to paternalism is made on the basis that an exercise of government power to substitute individual preferences is restrictive of fundamental rights when other interventions exists.'[139]

While Bartlett recognises that there may be a degree of paternalism in NCD prevention efforts, he contends that these policies may be justifiable where they avoid negative externalities – and even where interventions limit individual rights, they may be warranted if these limitations are proportional.[140] This aligns with the components of justifiable limitation under section 36 of the Constitution.

Hastings expands on the relationship between paternalism and individual choice, specifically in relation to the loss of choice that has occurred with the growing power of corporate actors.[141] He argues that consumers have not only lost their freedom, but that this perception of loss emanates from the marketing and promotion of unhealthy products by large corporations.[142] Hasting's arguments are particularly applicable to the influence of marketing on individual autonomy, but their more general nature is summarised as follows:

> 'Nanny state claims assume that individuals are free agents at risk of losing their freedom to an intrusive and overbearing state … [C]onsumers have not only lost their freedom, but have surrendered it willingly, collaborating in the process of promoting and creating value for products that cause them serious harm. This is a global phenomenon that would not be possible without the value of symbolism, cleverly channelled through marketing and promotion … The goals of public health should neither be to micromanage individuals, nor merely to nudge them in a healthier direction. … Ultimately … individuals need to reclaim their sovereignty, withdrawing their cooperation from those who are responsible for the industrial epidemics of tobacco, alcohol and food that dominate global disease statistics.'[143]

While co-opting the HR framing, the actions of these companies in fact often undermine individual choices. Rights arguments are thus weaponised by industry actors to oppose government regulation, particularly by reducing public support for these interventions.[144] Yang

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[139] Ibid at 14.
[140] Ibid at 15.
[141] Gerard Hastings 'Public Health and the Value of Disobedience' (2015) 129 *Public Health* 1046 at 1051.
[142] Ibid.
[143] Roger Magnusson and Paul E. Griffiths 'Who's Afraid of the Nanny State? Introduction to a Symposium', SSRN Scholarly Paper ID 2662273 (2015) available at https://papers.ssrn.com/abstract=2662273, accessed 30 September 2021 at 2.
[144] Magnusson,op cit note 130 at 1080.

et al posit that if correctly framed, HR offer an antidote to this narrative, offering a mechanism to legitimise government action to prevent NCDs.[145]

Interventions may have the effect of harming the interests, and potentially rights, of corporate actors whose products are being regulated.[146] Here, HR have been further leveraged by industry actors through the judicial system. Often regulatory efforts targeting unhealthy commodities have been subject to legal challenges almost immediately after passage, contributing significantly to regulatory chill.[147] Lee describes a series of legal cases where manufacturers of unhealthy commodities challenged regulations on the basis that their rights were being infringed.[148] In Canada, for example, legislation limiting the advertising of tobacco products was challenged on the grounds that it infringed the industry's right to freedom of expression.[149] This infringement was considered justifiable given the risks and harmful health effects of smoking.[150] This is similar to the British American Tobacco cases challenging a similar ban on advertising in South Africa, as discussed in previous Chapters. There is a need in cases where NCD prevention efforts work to limit industry rights to ensure the infringements are justifiable.[151]

Often overlooked in these framings of HR in relation to NCD prevention is how rights may provide support for policies and government action. In the previous Chapters, the rights which can support NCD prevention efforts were discussed in some detail, concretising state obligations and proffering support for the adoption of novel legal interventions aimed at improving health and diet. The use of socio-economic and other rights can be invoked to support and even compel action on NCDs to ensure fulfilment and realisation of rights. In this regard, Yang et al contend that an HR-based approach to NCDs which combats industry narratives needs to underscore the primacy of the right to health over civil and political rights, while also arguing for the limitation of rights-based claims where they have a high society cost. However, the supportive relationship goes even further than this. As discussed in Chapter 5, producers of unhealthy commodities are not solely rights bearers or holders, but also have HR obligations themselves – including to respect the rights of others.[152] Here the negative obligations that arise from the rights to health and food may provide the means for limiting

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[145] Yang, Mamudu and John op cit note 507 at 70 where it states 'the first step in altering power relations in NCDs governance is to cultivate the productive power of other stakeholders to develop and legitimize alternative approaches. These include human rights (see below), justice, ethics, health equity, and other frames. Academic institutions and civil society groups in particular have an important role to play in establishing and advocating for an alternative basis for NCD governance'.

[146] Patterson et al op cit 116 at 52.

[147] Eric Crosbie and George Thomson 'Regulatory Chills: Tobacco Industry Legal Threats and the Politics of Tobacco Standardised Packaging in New Zealand' (2018) 131 *The New Zealand Medical Journal* 25; Penelope Milsom, Richard Smith and Simon Moeketsi Modisenyane et al 'Do International Trade and Investment Agreements Generate Regulatory Chill in Public Health Policymaking? A Case Study of Nutrition and Alcohol Policy in South Africa' (2021) 17 *Globalization and Health* 1; Oleksandra Vytiaganets 'Smoking Chills? Tobacco Regulatory Chill, Foreign Investment, and the NCD Crisis in the Post-Soviet Space: A Case Study from Ukraine' (2020) 21 *The Journal of World Investment & Trade* 753.

[148] Lee op cit note 133 at 173.

[149] Ibid.

[150] Ibid.

[151] Ibid.

[152] A more detailed discussion of this concept is outlined in the discussion of duty-bearers outlined in Chapter 2 and it is further expanded upon more in Chapter 5.

their ability to make claims based on rights.[153] In combination, these two HR framings of NCD prevention can buttress state action and provide both legal and political bases for state interventions to address the NCD epidemic.[154]

III. ROLE OF AN HUMAN RIGHTS-BASED APPROACH IN NCD PREVENTION

A HR-based approach to NCD prevention is not novel and has been explored by a number of scholars under the rubric of international HR law. These approaches have been developed with a view to building on the successful application of HR frameworks to inform the HIV response. Patterson et al in particular highlight the utility of a HR-based approach and conceptual framework for obesity-related NCD prevention against the backdrop of the HIV response.[155] They outline key benefits that a HR-based approach to obesity prevention can offer: (1) clarifying and providing normative guidance on a state's obligation to prevent obesity-related NCDs; (2) serving as a catalyst and tool for civil society to demand action on NCDs; and, (3) providing a basis for states to act against private actors whose products are vectors for obesity and obesity-related illnesses.[156]

Figure 2 below outlines how an HR-based approach to obesity prevention may assist in improving health outcomes, highlighting how such an approach may be used, inter alia, to clarify the legal obligations of states and to hold states accountable.[157]

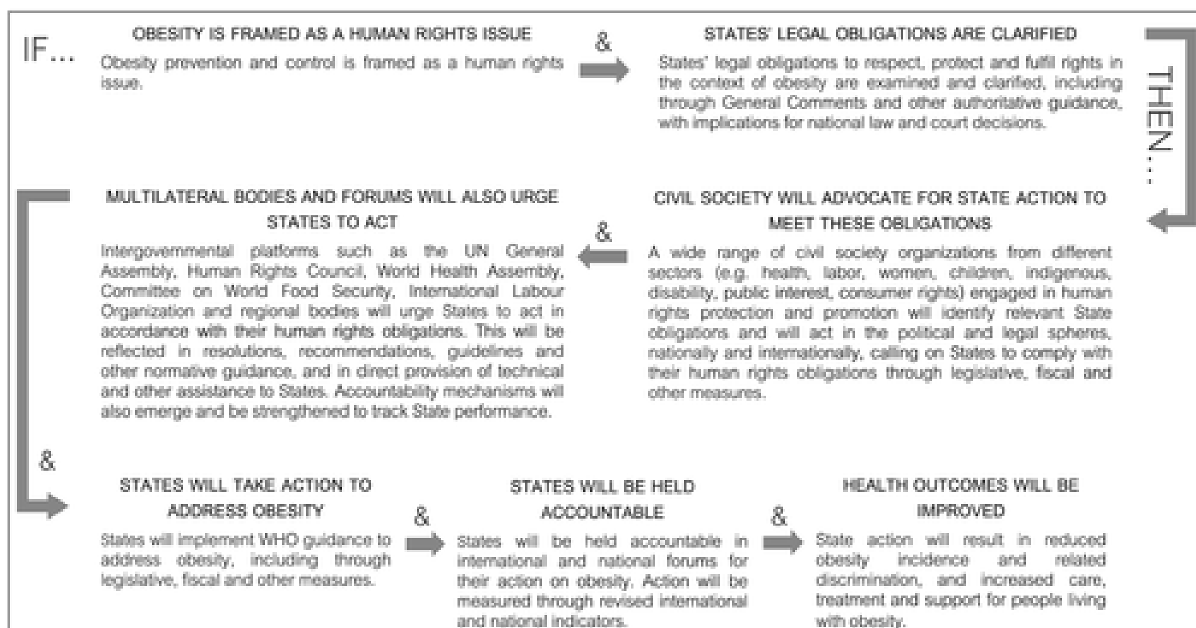

Figure 2: How human rights-based approach can advance the obesity agenda from Patterson et al[158]

[153] Yang, Mamudu and John op cit note 507 at 70.
[154] Ibid at 74.
[155] Patterson et al. supra note 126 at 48.
[156] Ibid.
[157] Ibid.
[158] Ibid.

IV. THE APPLICATION OF HUMAN RIGHTS TO NCDS

There have been several attempts to develop a HR-based approach to NCDs by various authors, each focussing on different components of the epidemic. This section will briefly summarise the existing literature on HR-based approaches to NCDs.

One of the first attempts to develop an HR-based approach to NCDs came from Gruskin et al, who identified the relationship between NCD prevention and HR as potentially synergistic.[159] In a brief comment, the authors highlight how the objectives of HR and those of public health are complementary in seeking to ensure that people live in conditions which promote health and enable them to live healthy lives.[160] If translated to norms and standards, HR can provide a mechanism for accountability and action across sectors.[161] In particular, Gruskin et al suggest HR as a pathway to action on NCDs, identifying four areas where HR could offer particular value. The first is in the regulation of unhealthy commodities and associated sectors, as well as the enablement and promotion of healthier behaviours through the implementation of evidence-based regulations and laws. This includes measures such as sodium restrictions to limit the amount of salt in food or the Framework Convention on Tobacco Control.[162] Further, determinants of NCDs and poor health can be framed using HR principles, allowing for the targeting of vulnerable populations using these interventions. Secondly, the application of HR principles to the NCD response assists in developing a response which is meaningful and culturally acceptable. This could include ensuring treatments adhere to the A3Q framework in being acceptable, available, accessible and of sufficient quality.[163] Thirdly, HR can offer a mechanism for supporting the implementation and monitoring of international norms and standards, ensuring accountability at a government level. Finally, framing an NCD response in terms of HR enables us to utilise existing infrastructure to ensure implementation and accountability, such as the existing reporting infrastructure around the ICESCR.[164]

Since Gruskin et al's 2014 paper, emergent literature on the relationship between the HR-based approach and NCDs has focused on locating the NCD response within specific HR that could be used to support action. This scholarship has focused largely on the rights to health and food as the primary mechanisms to support an HR-based approach to NCDs. The following sections will outline the scholarship that has emerged around each right.

(a) The right to health

A significant proportion of the literature on the HR-based approach and NCDs focuses on anchoring action within the right to health. Ferguson et al, for example, conceptualise a HR-based approach to NCD prevention as part of a state's obligation to progressively realise the

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[159] Sofia Gruskin, Laura Ferguson and Daniel Tarantola et al 'Noncommunicable Diseases and Human Rights: A Promising Synergy' (2014) 104 *American Journal of Public Health* 773 at e1.
[160] Ibid.
[161] Ibid.
[162] Ibid.
[163] Ibid at e1-2.
[164] Ibid at e2.

right to health, which in terms of the ICESCR includes not only the provision of healthcare services, but also measures to address the underlying determinants of health.[165] They summarise what fundamentally constitutes a HR-based response to NCD control and prevention, noting that HR would inform both the form and content of the response:

> 'A human rights-based approach to NCDs would require the adoption of an approach explicitly shaped by human rights principles, norms and standards and specific attention to the key elements of the right to health. In particular, participation, equality and non-discrimination, attention to the legal and policy environment, and accountability are of critical importance to the implementation of the right to health. Further, as this right encompasses standards requiring health facilities, goods and services to be available, accessible, acceptable and of sufficient and measurable quality these attributes can crucially impact NCD prevention and control.'[166]

In this sense, the 'right to health' approach adopted by Ferguson et al frames the content of an HR-based approach to NCD prevention in terms of the healthcare system. However, they do recognise that the 'drivers of NCDs are connected to national policy as well as social, environmental and corporate behaviours' and, as such, an HR-based approach has particular value. They expressly recognise that the intersection of various HR is critical in formulating a HR-based approach,[167] outlining the shortcomings of NCD prevention approaches that focus too heavily on the healthcare system to the exclusion of determinants across other sectors:

> 'Without discounting the biological risk factors for NCDs and the need for a medical response, the critical influence of behaviours of individuals and corporations on NCD outcomes underscores the need for action beyond the health sector. Human rights are described as indivisible and interdependent because they all have equal status, and cannot be positioned in a hierarchical order, and the fulfilment of one right often depends, wholly or in part, upon the fulfilment of others.'[168]

In their review of existing international policies, Ferguson et al identify a significant emphasis on the provision of healthcare services or treatment as a core component of the right to health content in these documents.[169] Yet they find sparse reference to addressing the specific drivers and underlying determinants of the NCD epidemic, and even fewer references to rights other than the right to health in many documents. However, the WHO's 'Diet, Nutrition and the Prevention of Chronic Diseases Report' does recognise a right to sufficient and nutritious food as part of addressing NCDs, specifically supporting government efforts to make nutrient dense foods available and accessible.[170] Ferguson et al specifically question whether this limited focus on the availability and accessibility of healthcare services is sufficient to enable a practical HR-based response to the epidemic.[171] Critically, they note that even where HR are invoked in these policy documents, there is usually little analysis or explanation of their meaning, content or accompanying obligations. This creates difficulty in utilising HR to guide policy and legislative action on NCDs.[172]

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[165] Ferguson et al op cit note 102 at 1202.
[166] Ibid at 1201.
[167] Ibid at 1203.
[168] Ibid at 1217.
[169] Ibid at 1215.
[170] World Health Organization 'Diet, Nutrition and the Prevention of Chronic Diseases' (2003) available at http://whqlibdoc.who.int/trs/who_trs_916.pdf, accessed 10 November 2021 at 139.
[171] Ferguson et al op cit note 102 at 1215–6.
[172] Ibid at 1216.

Ferguson et al suggest a two-pronged approach to improving the utility of HR in NCD prevention policies: first, HR should be operationalised to offer specific guidance on how HR can inform NCD responses;[173] secondly, they suggest the inclusion of HR indicators as part of monitoring and evaluating NCD responses at a local level.[174] Ó Cathaoir adapted this broader HR approach to the narrow issue of childhood obesity and attempted to formulate a more robust approach centred on the Convention of the Rights of the Child and the right to health.[175] This reliance on the more unqualified rights of the child offers a stronger pathway towards the implementation of interventions, yet these would then be limited to interventions that primarily target and benefit children.

Anand Grover, the UN Special Rapporteur on the Right to Health, developed a report on unhealthy foods, non-communicable diseases and the right to health which offers perhaps the most significant contribution to concretising the obligations to address NCDs that arises from the right to health.[176] In this report, Grover expressly outlined the state's obligations to respect, protect and fulfil the right to health in the context of unhealthy foods. Specifically, Grover highlighted mechanisms to address unhealthy foods as risk factors and how these may intersect with the state's obligations under the right to health. Grover emphasised the need for a state to regularly update food and nutrition guidelines and implement consumer-friendly labelling of food products.[177] In addition, he suggests the use of fiscal policies to dis-incentivise the consumption of unhealthy foods alongside the implementation of regulatory frameworks to reduce children's exposure to the marketing of unhealthy foods.[178] Grover also discusses aspects of HR related to the responsibility of the food and beverage industry, and recognises that the right to health requires that industry 'refrain from engaging in activities that negatively impact the right of people to the highest attainable standard of health'.[179]

(b) The right to food

Alongside access to health, the right to food is another right often relied upon by scholars in seeking to develop an HR-based approach to NCDs. Grover's identification of unhealthy food specifically as a target for action to address NCDs and protect the right to health is mirrored in De Schutter's 2011 Report to the Human Rights Council, where he discussed the right to food and the 'triple challenge' of food security, adequate nutrition and overweight and obesity.[180] One of the most notable aspects of De Schutter's report is the discussion of poverty and its links to NCDs. De Schutter argues that while poorer householders may be less educated about

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[173] Ibid.
[174] Ibid.
[175] Katharina Ó Cathaoir 'Childhood Obesity and the Right to Health' (2016) 18 *Health and Human Rights* 249 at 256.
[176] Anand Grover 'Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health: Unhealthy foods, non-communicable diseases and the right to health' (2014), available at http://www.unscn.org/files/Announcements/Other_announcements/A-HRC-26-31_en.pdf, accessed 1 February 2019 at 8.
[177] Ibid at 8.
[178] Ibid at 9–10.
[179] Ibid at 12.
[180] Olivier De Schutter 'Report submitted by the Special Rapporteur on the right to food' (2011) available at https://www.ohchr.org/Documents/HRBodies/HRCouncil/RegularSession/Session19/A-HRC-19-59_en.pdf, accessed 1 February 2019.

unhealthy diets, they may also lack the resources to improve their diets.[181] In addition to changes to agri-food systems, De Schutter suggests using taxation as an instrument to encourage healthy diets, regulating marketing, and re-examining existing subsidies. The approach adopted by De Schutter recognises the need to improve diets and encourage consumption of healthy foods alongside the need to protect existing food systems (particularly in LMICs) as all integral to enabling healthy diets. De Schutter suggests a dual role for the HR framework to both protect the right to an adequate diet and ensure a transition to more sustainable diets.[182] This explicitly infuses the right to food with a consideration of nutrition, specifically embedding the need for a healthy diet within the content of the right to food.

This concept was further developed by Ayala and Meier, who discussed a HR-based approach to address the health implications and effects of food and nutrition insecurity, and drew jointly on both the right to food and the right to health.[183] They argue that the concept of 'food insecurity' lies at the intersection of the right to food and health, defining it as 'a situation that exists when people lack secure access to sufficient amounts of *safe and nutritious food* for normal growth and development and an active and *healthy life.*'[184] Their approach places nutrition security[185] as a starting point to include both the under- and over-nutrition of people as potential violations of the right to food and nutrition security.[186] Specifically, Ayala and Meier argue that since good nutrition can protect humans from disease, addressing nutrition insecurity is needed for the achievement of public health objectives.[187] Referring to ICESCR, Ayala and Meier highlight the recognition of good nutrition and food as part of the right to health and an emphasis on adequate nutrition to imbue the right to food with considerations of health – thereby developing the right to health and food into intersectional rights.

Within this intersectional framing of the rights to food and health, obligations are framed in terms of the A3Q framework as follows:

- Ensuring that food is available at a national level through consideration of not just food production but global determinants of food security, such as trade and economic policies;
- Ensuring that food becomes geographically and financially accessible at a household level;
- Ensuring that food meets notions of acceptability, including cultural appropriateness as well as meeting the nutritional needs of particular populations;

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[181] Ibid at 8.
[182] Ibid at 20.
[183] Ana Ayala and Benjamin Mason-Meier 'A Human Rights Approach to the Health Implications of Food and Nutrition Insecurity' (2017) 38 *Public Health Reviews* 10 at 12.
[184] Ibid (emphasis added).
[185] Ayala and Meier reference the FAO's definition of nutrition security is '[a] situation that exists when secure access to an appropriately nutritious diet is coupled with a sanitary environment, adequate health services and care, in order to ensure a healthy and active life for all household members'. See Food and Agriculture Organization of the United Nations 'The state of food insecurity in the world' (2015) available at http://www.fao.org/3/a-i4646e.pdf, accessed 6 December 2017.
[186] Ayala and Meier op cit note 162 at 11.
[187] Ibid at 12.

- Ensuring that food is adequate to the extent that it addresses nutrition as an underlying determinant of health, thus expanding consideration of adequacy beyond caloric sufficiency to include nutritional standards.[188]

Ayala and Meier acknowledge that the concept of food security has developed significantly over time in light of emerging challenges. Initial discussions of food security focused on the availability of sufficient food, but by 1996 there was growing recognition in the international community that nutrition was integrally linked to health.[189] The definition of nutrition evolved to include physical and economic access to food that is safe, nutritious and sufficient to meet dietary needs. Explicit in this more comprehensive definition is the acknowledgment that food and nutrition are underlying determinants to living a healthy life.[190] The Food and Agricultural Organization (FAO) identified four domains across which the right to food must be realised: availability of food; economic and physical accessibility of food; utilisation of nutrients in food; and stability of the preceding three domains. Ayala and Meier frame malnutrition in its varying forms as a primary challenge to nutrition and food security, as well as the right to food.[191] In discussing over-nutrition and obesity as contributors to NCDs, the authors attribute the growing prevalence of NCDs to the globalisation of unhealthy diets, marketing and the lack of regulation of the food industry. Access to food is often heavily determined by structural and social conditions outside of the control of an individual.[192] Drawing on this, Ayala and Meier frame the obesity epidemic as an 'industry epidemic', and highlight how HR obligations can assist states in introducing measures to control and regulate unhealthy industries.[193] Ayala and Meier conclude by highlighting that food and nutrition security are central to individual dignity and provide a foundation for the enjoyment of other rights.[194]

As has been discussed above, the components of an HR-based approach to the epidemic can often include: (1) mapping the epidemic and diagnosing those with NCDs; (2) strengthening access to healthcare for those living with NCDs; and, (3) reducing the availability and accessibility of modifiable risk factors.[195] It is the third component, centred on targeting risk factors, which is the particular focus of a HR-based approach to NCD prevention when compared to a HR-based approach to NCDs more generally. Nygren-Krug characterises this preventative directive in terms of the World Health Assembly's draft action plan on the prevention and control of NCDs, which emphasises the need to reduce individual and population exposure to modifiable risk factors and their determinants while also strengthening 'the capacity of individuals and the population to make healthier choices and follow lifestyle patterns the foster good health.'[196] In this sense, the preventative component of a HR-based approach to NCDs might focus on interventions to reduce the availability, accessibility and acceptability of modifiable risk factors such as tobacco, alcohol and unhealthy diet at a

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[188] Ibid at 20.
[189] Ibid at 12.
[190] Ibid.
[191] Ibid at 14.
[192] Ibid at 22.
[193] Ibid at 17.
[194] Ibid at 22.
[195] Nygren-Krug op cit note 132 at 264.
[196] Ibid.

population level, along with efforts to improve behaviour and decision-making at an individual level.

In applying specific HR to the prevention and control of NCDs, Nygren-Krug identifies the right to health as a central tenet of the approach. Unlike other approaches which anchor the right to health as a means for improved treatment and healthcare infrastructure, however, her approach frames this as a 'right to enjoyment of a variety of facilities, goods, services and conditions necessary for the realisation of the highest attainable standard of health'. This is elaborated further in her recognition that a rights-based approach offers a means for addressing more than just the immediate causes of NCDs, but also tackling their deeper underlying causes.[197] Specifically, Nygren-Krug suggests that an HR-based approach can go 'beyond the behavioural risk factors' (individuals behaviours like over-eating or smoking) and instead consider how individual behaviours are affected by the environmental factors linked to human rights. She outlines how individual behaviours can be influenced by that individual's enjoyment or non-enjoyment of human rights related to health, such as the right to safe and healthy working conditions, food, information and education.[198] This kind of approach was also outlined in more recent CESCR comments which signalled a change from viewing NCDs simply as the result of individual behaviours and genetics to instead recognising how these diseases arise from the underlying determinants of health.[199]

V. A HUMAN RIGHTS-BASED APPROACH TO NCDS IN THE AFRICAN REGION

The extent to which NCDs are recognised in African HR instruments will be discussed in Chapters 3 and 4. This section of the literature review seeks to outline in brief the existing literature on an HR-based approach to NCDs in the African region. There has been only limited discussion around the application of HR frameworks to NCD prevention in the region. Leading contributions are offered by Twinomugisha, who seeks to apply a right to health framework in addressing NCDs in Uganda,[200] and Durojaye and Aboubakrine, who focus on formulating the approach for indigenous populations in Africa.[201]

Twinomugisha considers how the right to health can be used to address NCDs in the increasingly neoliberal economic context of Uganda.[202] He frames the NCD epidemic and policies to address it as having been heavily shaped by a neoliberal paradigm which promotes the supply and consumption of unhealthy commodities.[203] Importantly, this paradigm emphasises notions of individual choice and freedom. In the context of NCDs, this underscores a narrative which holds individuals responsible for making healthy choices, while minimising the role of structural and systemic factors which, in practice, constrain this freedom.[204] Twinomugisha explicitly rejects this emphasis on individual responsibility:

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[197] Ibid at 265.
[198] Ibid.
[199] General Comment 14 at para 4 as discussed above.
[200] Benjamin Twinomugisha 'Using the Right to Health Framework to Tackle Non-Communicable Diseases in the Era of Neo-Liberalism in Uganda' (2020) 20 *African Human Rights Law Journal* 147.
[201] Ebenezer Durojaye and Mariam Wallet Aboubakrine 'Adopting a Rights-Based Approach to Non-Communicable Diseases among Indigenous Peoples in Africa' (2019) 26 *International Journal on Minority and Group Rights* 138.
[202] Twinomugisha op cit note 178 at 148.
[203] Ibid.
[204] Ibid at 150-1

> 'Current prevention, control and management efforts that frame the question of NCDs as apolitical by focusing primarily on individual behaviour or lifestyle changes are likely to fail unless structural factors that shape the NCD burden are tackled. Prevention measures through lifestyle changes are critical for the patient and health system. A person's choice and behaviour play a crucial part in explaining the outset of NCDs. However, the political, economic and social context in which the diseases are located and reproduced cannot be ignored. The role of the social determinants of health, including poverty, gender and social inequalities, the level of education, nutrition, and environmental conditions, should be recognised. The contribution of processes such as trade liberalisation and the marketing activities of transnational corporations to the burden of NCDs should also be recognised.'[205]

Twinomugisha sees the right to health as a mechanism to address this neoliberal framing. He outlines three domains in which the right to health framework may assist in the prevention and treatment of NCDs. The first is the adoption of juridical measures such as laws, policies and regulations which promote health and protect individuals from the harmful effects of consuming unhealthy commodities like tobacco.[206] As part of this, government has an obligation to protect the public from the influence of commercial industry actors.[207] Twinomugisha further contends that the state's obligations to promote, protect and respect the right to health requires that states act to ensure that the producers of unhealthy commodities should not adversely affect people's health. Twinomugisha argues that food and soft drink industries need to be regulated to address the right to food holistically (including through advertising regulations).[208] Second, he argues that constitutional rights litigation can be an important tool in the prevention and control of NCD, specifically referring to tobacco litigation in South America and other countries which worked to limit the use and promotion of tobacco products.[209] Third, he argues that a right to health framework can support community participation in NCD care and in the development of food policies which promote the growth and production of healthier foods. Finally, Twinomugisha contends that a HR framework can contribute to addressing the inherently gendered nature of the NCD epidemic.[210]

Durojaye and Aboubakrine have outlined the importance of adopting a HR-based approach to NCDs in the context of indigenous populations, underscoring the relationship between NCDs and the underlying social determinants of health that influence health outcomes.[211] The authors recognise that the NCD epidemic amongst indigenous populations is burgeoning both as a result of both nutrition transition (and is thus preventable) and a lack of access to healthcare services, with high levels of undiagnosed NCDs in certain populations. They thus argue that the issues faced by indigenous populations are reflective of the broader challenges NCDs pose within the region, and conclude that:

> 'adopting a rights-based approach to this situation provides a powerful way of addressing the main causes of NCDS (especially among indigenous populations), including poverty, ethnicity, economic exclusion, non-discrimination, and other socially determined barriers.'[212]

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[205] Ibid at 179.
[206] Ibid at 167.
[207] Ibid at 168.
[208] Ibid at 170.
[209] Ibid at 173.
[210] Ibid at 177.
[211] Durojaye and Aboubakrine op cit note 179 at 147.
[212] Ibid.

Durojaye and Aboubakrine call for drastic measures to ensure indigenous populations have access to healthcare goods and services and, more importantly, that there are efforts to address structural barriers which serve to limit the access these populations have to healthcare information and services as part of their HR – specifically under the right to health.[213] Durojaye and Aboubakrine emphasise that the provision of healthcare information as a means of empowering marginalised populations to exercise informed autonomy over their health and avoid preventable deaths from NCDs.

Though the issues raised by Durojaye and Aboubakrine have significant bearing on the treatment of NCDs and the prevention of NCD-related deaths, the emphasis on education is an oft touted silver bullet to NCD prevention. However, in practice, education can only be effective when coupled with other interventions that target environmental and societal factors.[214] It clear that the social determinants of health play a very direct role in both the prevention and development of NCDs across all populations.[215] In particular, access to food, water, and related information – including information on the nutritional composition of food and the kinds of food needed to maintain good health – can play a more significant role in prevention of NCDs than access to healthcare services and early diagnosis of risk factors. The role of HR in relation to these determinants is not discussed in detail by the authors.

VI. NEED TO DEVELOP A HUMAN RIGHTS-BASED APPROACH THAT IS CONTEXT SPECIFIC TO SOUTH AFRICA

The above discussions illustrate both the value of developing an HR-based approach to NCDs and the importance of reflecting on the diversity of such approaches. This value can only be realised, however, if the broad obligations outlined in international instruments can be translated to the domestic context and concretised within domestic legal instruments such as national constitutions and legislation.[216] This requires not only anchoring the approach in broad HR principles but identifying specific rights in which to locate the NCD prevention response. As Ferguson outlined:

> 'Human rights provide an internationally recognised legal framework under which governments have concrete obligations relevant to NCDs. However, these obligations should be further articulated to better address the challenges posed by NCDs, not only in relation to the rights to life, health, food and education but also in relation to the human rights responsibilities of the private sector … [H]uman rights norms should be further and better articulated to incorporate the risk factors and underlying determinants of NCDs.'[217]

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[213] Ibid at 148–9.
[214] Ross Arena, Marco Guazzi, Liana Lionov et al 'Healthy Lifestyle Interventions to Combat Noncommunicable Disease—a Novel Nonhierarchical Connectivity Model for Key Stakeholders: A Policy Statement from the American Heart Association, European Society of Cardiology, European Association for Cardiovascular Prevention and Rehabilitation, and American College of Preventive Medicine' (2015) 36 *European Heart Journal* 2097.
[215] Günter Diem, Ross C. Brownson, Vilius Grabauskas et al 'Prevention and Control of Noncommunicable Diseases through Evidence-Based Public Health: Implementing the NCD 2020 Action Plan' (2016) 23 *Global Health Promotion* 5.
[216] Ayala and Meier op cit note 162 at 20.
[217] Ferguson et al op cit note 102 at 1205.

For this reason, there is a need to develop a context-specific HR-based approach to NCD prevention – the primary aim of this thesis. Before moving on to the development of this approach, however, it is necessary to consider the existing HR-based approach to NCD prevention as contained in policies and laws adopted in South Africa – particularly given how extensive existing NCD prevention efforts are.

(a) The approach adopted in South African policies

Although most literature anchors a HR-based approach to NCD prevention and control in the right to health, there is recognition that multiple rights are implicated and may be used to support different aspects of control and prevention. The question that remains in the South African context is how this approach can be adapted and formulated to fit within the framework of the Bill of Rights and the Constitution.[218]

A HR-based approach is frequently invoked by the National Department of Health in their policies related to NCD prevention. In 2011, for example, the Department convened the first South African Summit on the Prevention and Control of NCDs which led to the adoption of a declaration that set out a number of targets for the prevention and control of NCDs,[219] as well as an overall strategic vision for NCD control in South Africa ('the Declaration').[220] The Declaration explicitly recognises the human right to health in its preamble and, consequently, as a part of the foundation for preventing and controlling NCDs.[221]

Following this, the Department published a five-year strategic plan on NCD prevention and control which outlined an inter-sectoral approach, along with targets for the years 2013-2017.[222] This Strategic Plan makes reference to the Moscow Declaration and the role of NCD prevention in fulfilling the right to health.[223] Subsequently, a draft Strategic Plan for 2020-2025 was published, although it does not appear to have been formally adopted. This document explicitly adopts a HR-based approach to NCD prevention, but, as with the previous strategic plan, does not anchor this approach in any specific South African constitutional rights.[224] The document invokes the child's right to the highest attainable standard of health to support the adoption of measures that address childhood obesity.[225] The draft plan also adopts a 'life course

[218] Sections 8-36 of the Constitution of the Republic of South Africa, 1996.
[219] The targets included reducing tobacco, alcohol and salt consumption, improved screening for NCDs and an overarching goal of reducing premature mortality from NCDs by 2020. The 2012 Declaration at 5-7.
[220] Delobelle et al. op cit note 25 at 71S.
[221] The preamble of the Declaration recognises 'the right of all South Africans to the enjoyment of the highest attainable standards of physical and mental health' which echoes the right to health contained in the first WHO Constitution (1946) as well as the wording of Article 12 of the International Covenant on Economic, Social and Cultural Rights Assembly, UN General Assembly, United Nations, treaty series 993.3 (1966).
[222] Department of Health, Strategic Plan for the Prevention and Control of Noncommunicable Diseases 2013-17, RP06/2013 available at https://www.health-e.org.za/wp-content/uploads/2013/09/NCDs-STRAT-PLAN-CONTENT-8-april-proof.pdf , accessed 10 November 2017 (the NCD Strategic Plan)
[223] Ibid.
[224] National Department of Health, Draft Strategic Plan 2020-5 available at https://www.samedical.org/file/1202, at 68
[225] Ibid at page 116

approach' linking the social determinants of health and the promotion of HR to the improvement of health.[226]

Of all the policies adopted, the Health Promotion Policy and Strategy is most clearly and explicitly anchored in specific constitutional rights. The Health Promotion policy seeks to address health comprehensively by addressing each of the epidemics that constitute South Africa's quadruple burden of disease, including NCDs.[227] It anchors the policy objectives in the Constitution under the section 24 right to a healthy environment as well as the section 27 rights.[228] Section 24, which provides that everyone has a right to an environment that is not harmful to their health or wellbeing, has been cited in a number of the Department of Health's policies.

VII. CONCLUSION

As was discussed in Chapter 1, the NCD epidemic in South Africa is to a large degree preventable through the regulation of modifiable risk factors, and the law is particularly well placed to address the availability, accessibility and acceptability of unhealthy commodities. In addition, there has already been substantial work on improving the accessibility and availability of treatment for NCDs under both international and regional instruments as well as in scholarship. What remains under-developed in scholarship is the application of HR frameworks to NCD prevention, despite the fact that NCDs, particularly food- and obesity-related NCDs, are preventable. For this reason, the next Chapter of this dissertation will focus exclusively on the application of a constitutional rights framework to NCD prevention in South Africa.

The foundations of an HR-based approach to NCDs have been put in place in policy documents, but there is a need to adopt a more coherent and legally robust approach to enable us to realise the full benefits of an HR-based approach to NCDs. The starting point for any HR-based approach to NCDs must be to identify rights that support prevention activities. The right to health and the right to food are most often invoked in the literature, so this thesis will investigate and develop content within both of these rights in the South African context which could be used to support NCD prevention efforts.

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[226] Ibid at page 115 which reads: 'The life-course approach focuses on how multiple determinants interact to affect health throughout life and across generations. Health is considered as a dynamic continuum rather than a series of isolated health states. The approach highlights the importance of transitions, linking each stage to the next, of defining protective risk factors, of prioritizing investment in health care and social determinants of health, and of gender equality and *the promotion of human rights* early in the life-course' (emphasis added).
[227] Health Promotion Strategy at 8
[228] Ibid at 6.

CHAPTER 3
THE SCOPE OF THE RIGHT TO HEALTH IN SOUTH AFRICA AND ITS APPLICATION TO NCD PREVENTION

I. INTRODUCTION:

The preceding Chapter demonstrated that locating action on NCDs within a HR framework requires more than just consideration of the right to health in relation to the healthcare sector. Instead, it requires a consideration of how the right to health may apply to the underlying determinants of health, particularly nutrition and food, as well as public health interventions that are situated outside the healthcare system (also known as non-pharmaceutical interventions or NPIs).

The extent to which the right to health encompasses NPIs is particularly relevant when concretising these concepts within the South African Constitution, given the structure and content of the Bill of Rights. This Chapter will discuss the content of the right to health outside healthcare as a starting point to locate NCD prevention action within the right. This will include discussion of the right to health under international and regional law. The right to health under the South African Constitution will then be discussed with a view to understanding its content as captured in both section 27(1)(a) and other rights. The Chapter will then discuss how the right to health has been developed and defined through jurisprudence. Finally, the inclusion and application of the right to health to non-pharmaceutical interventions outside the healthcare sector will assist in understanding the operation of section 27(1)(a) outside the ambit of healthcare. Here, both seminal and novel COVID-19 (SARS-CoV-2) related case law will be considered to understand the development of this right in relation to public health efforts over time.

II. THE RIGHT TO HEALTH AS MORE THAN A RIGHT TO HEALTHCARE

The right to health has been developed over the past seven decades and its scope has evolved.[229] Significant attention in the development of the right has been placed on access to, and availability of, healthcare services, with universal health coverage considered a cornerstone of the right to health.[230] The Declaration of Alma Ata,[231] which prompted a renaissance on the right to health, focused on primary healthcare. In the context of the response to the HIV/AIDS epidemic, which came to be anchored in HR, respect for HR were recognised as central to an effective public health response. Nevertheless, the role of the right to health remained focused on biomedical interventions, such as the right to access affordable medicines.[232]

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[229] Gostin et al op cit note 121 at 2731.
[230] Lawrence O. Gostin, John T. Monahan, Jenny Kaldor et al 'The Legal Determinants of Health: Harnessing the Power of Law for Global Health and Sustainable Development' (2019) 393 *Lancet* 1857 at 1872.
[231] Declaration of Alma-Ata, International Conference on Primary Health Care, Alma-Ata, USSR, 6–12 September 1978 (2004) 47 Development 159 available at https://www.who.int/publications/almaata_declaration_en.pdf. (Declaration of Alma Ata)
[232] Gostin et al op cit note 121 at 2731.

In 2005, Meier and Mori recognised that addressing the antecedents to good health, and in particular moving beyond biomedical interventions to focus on underlying determinants of health, would be central to the realisation of the right to health.

> 'Health rights, like other individual economic, social, and cultural rights, 'plac[e] obligations on government to act for the communal good'. Rather than being viewed solely as a Millsian intrusion on individual liberties, modern public health programs can be framed expansively as part of a social justice movement for shaping the underlying societal determinants of health, codifying nascent public health norms and researching ways to improve the health of the public and the individual in the modern era of globalization. Through this broader construction of health rights, public health measures may enhance individual and collective rights by alleviating harmful societal determinants of health and assuring the provision of public goods necessary for beneficial health outcomes.'[233]

The central place accorded to healthcare in the normative content of the right to health belies the fact that healthcare plays a smaller role in health outcomes than the environmental, social and economic circumstances of an individual.[234] Consequently, there is a need to conceptualise the right to health as broader than just a right to healthcare, and to identify its content in relation to other sectors.

This expanded view was articulated in Mann's framework, which recognised the complementarity of the right to health and other HR.[235] This is a view of human wellbeing predicated on the realisation and protection of other HR, including the underlying determinants of health.[236] Gostin proposed a framing of the right to health which adopted both the underlying and social determinants of health (SDOH) approach, stating:

> 'The right to health is not confined to health care but embraces a wide range of socio-economic conditions necessary for people to lead healthy lives including the underlying determinants of health (nutrition, housing, uncontaminated drinking water, sanitation, safe workplaces and a healthy environment).'[237]

During his tenure as the UN Special Rapporteur on the Right to Health, Paul Hunt identified the need to include underlying and SDOH within the definition of the right to health:

> 'The health of individuals, communities and populations requires more than medical care. For this reason, international human rights law casts the right to the highest attainable standard of physical and mental health as an inclusive right extending to not only timely and appropriate

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[233] Meier and Mori op cit note 103 at 119.
[234] The concept of social determinants of health broadly is discussed and explained in: World Health Organization, 'Commission on Social Determinants of Health and World Health Organization, Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health: Commission on Social Determinants of Health Final Report' (2008); Michael Marmot and Richard Wilkinson, *Social Determinants of Health* (2005).
[235] Mann et al op cit note 119 at 10.
[236] Ibid at 19 which reads 'The proposal that promoting and protecting human rights is inextricably linked to the challenge of promoting and protecting health derives in part from recognition that health and human rights are complementary approaches to the central problem of defining and advancing human well-being. This fundamental connection leads beyond the single, albeit broad mention of health in the UDHR (Article 25) and the specific health-related responsibilities of states listed in Article 12 of the ICESCR, including: reducing stillbirth and infant mortality and promoting healthy child development; improving environmental and industrial hygiene; preventing, treating and controlling epidemic, endemic, occupational and other diseases; and assurance of medical care'.
[237] Lawrence O. Gostin 'At Law: The Human Right to Health: A Right to the" Highest Attainable Standard of Health' (2001) 31 *The Hastings Center Report* 29, at 29.

> medical care but also the underlying determinants of health, such as access to safe water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, access to health-related education and information, including on sexual and reproductive health, and freedom from discrimination.'[238]

Scholars have subsequently echoed this sentiment and recognised the need to imbue the content of the right to health with a recognition of these other factors.[239] This approach is of particular relevance when seeking to address adverse health outcomes that arise from, or are impacted by, factors situated outside the healthcare sector. Given that NCDs are driven by unhealthy commodities and significantly affected by issues such as diet, nutrition and the consumption of products like tobacco and alcohol, an underlying determinants approach is needed to develop a HR-based approach to the epidemic. The NCD Alliance highlighted the importance of an SDOH and underlying determinants approach to the right to health when dealing with NCDs, highlighting the many facets of a rights-based approach to the NCD epidemic as follows:

> 'The right to health goes beyond access to health care. NCDs are affected by a number of underlying social, economic, cultural and political determinants of health and structural barriers. A human rights-based approach provides a practical way to address the social determinants of NCDs, including poverty, gender equality, ethnicity, economic exclusion, non-discrimination and other socially determined barriers.'[240]

Consequently, the application of the right to health to NCDs, and specifically the prevention of NCDs, requires a clear delineation of the content of the right to health outside the provision of, and access to, healthcare services. Though there are now some moves towards delineating this right to health beyond healthcare, the need to integrate a HR-based approach to the underlying determinants of health is becoming urgent – particularly in the context of preventing NCDs, where action is needed outside the healthcare sector.[241]

In South Africa, this more expansive conceptualisation presents a particular challenge, as section 27(1)(b) of the Constitution recognises a right to access to healthcare – and section 28 contains an entitlement to basic healthcare services for children – rather than a broader right to health. This Chapter will explore whether a definition of the right to health which includes underlying determinants is compatible with the South African constitutional dispensation, and it will investigate the scope of protection offered in terms of the right under the Bill of Rights. It will be argued that the content afforded to the right to healthcare under section 27(1)(b) is, in certain respects, broader than healthcare and has been used to protect and underpin a range

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[238] Paul Hunt 'Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health' *United Nations*, 31 January 31 2008 available at http://digitallibrary.un.org/record/619909, accessed 10 November 2021 at para 45.

[239] Audrey R. Chapman 'The Social Determinants of Health, Health Equity, and Human Rights' (2010) 12 *Health & Human Rights* 17; Gostin op cit note 217 at 29; Twinomugisha op cit note 178 at 149.

[240] NCD Alliance 'Non-Communicable Diseases (NCDs): The Human Rights Factor' available at https://ncdalliance.org/sites/default/files/rfiles/NCDs%20and%20Human%20Rights%20-%20longer%20doc%20(1%20July%202011).pdf, accessed 20 February 2021.

[241] Ibid at page 6, which states: 'The social determinants of health are the conditions in which people live and which affect their health status. A human rights direction tends to identify the state's obligations and assess the extent to which they are being fulfilled. The findings of the social medicine and social epidemiology communities, suggest that societies cannot improve the health status of their populations and reduce significant health inequalities solely or primarily by increasing the resources devoted to medical services'.

of non-pharmaceutical interventions (NPIs)[242] and actions outside the healthcare sector. On this basis, this Chapter argues that despite the limited wording on section 27(1)(b), there is indeed a constitutional right to health in South Africa and its content has been defined as including NPIs.

In advancing this argument, the Chapter begins by outlining the right to health and its inclusion of underlying determinants of health under international and regional law. The Chapter then discusses the right to health under the South African Constitution and its development in case law, specifically addressing the content of section 27(1)(a) in relation to individual and public health, as well as its application to interventions outside the healthcare sector. Recognising that the COVID-19 pandemic response relied significantly on NPIs and gave rise to extensive jurisprudence, the Chapter discusses this case law separately and considers how it defines health-related rights in relation to interventions outside the healthcare sector. It concludes by arguing that the South African Constitution contains a composite right to health which is codified through justiciable rights related to the underlying determinants of health.

III. THE SCOPE OF THE RIGHT TO HEALTH UNDER INTERNATIONAL LAW

(a) The right to health as defined by human rights instruments

The Preamble of the Constitution of the World Health Organisation (1946) recognised that 'the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being'. [243] The Preamble also codified a broad definition of health which extended beyond the absence of disease to include 'complete physical, mental and social well-being'. These statements amounted to the first recognition of a right to health, and even this early conceptualisation spoke of a broad right that expanded beyond ill-health, disease and injury.

Two years later, the Universal Declaration of Human Rights (UDHR) entrenched this right as one that not only encompassed health and physical well-being by adopting a social determinants of health (SDOH) framing to the right.[244] Article 25 reads:

> 'Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing, and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.'

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[242] NPIs are an armamentarium of public health interventions which are relied upon to control pandemics or epidemics. These interventions are often of paramount importance where there are limited or no biomedical or pharmaceutical interventions (such as vaccines) available to treat or prevent a disease. NPIs may include a variety of measures aimed at reducing or slowing the spread of a disease or altogether preventing it, such as voluntary or mandatory isolation and quarantine, social distancing, and travel restrictions. For a comprehensive review of NPIs within the context of the COVID-19 pandemic and elsewhere, see Natsuko Imai Katy A.M. Gaythorpe, Sam Abbott et al 'Adoption and Impact of Non-Pharmaceutical Interventions for COVID-19' (2020) 5 *Wellcome Open Research* 59; Nicola Perra 'Non-Pharmaceutical Interventions during the COVID-19 Pandemic: A Review' (2021) 913 *Physics Reports* 1.

[243] Constitution of the World Health Organization adopted by the International Health Conference held in New York from 19 June to 22 July 1946, signed on 22 July 1946 (WHO Constitution).

[244] Michael Marmot 'Social Determinants of Health Inequalities' (2005) 365 *The Lancet* 1099, at 1102.

Article 25 recognises that a person's health is constituted by more than just physical well-being and access to healthcare services. In this sense, it recognises the role of SDOH which sit outside the healthcare sector but have a direct bearing on a person's health and well-being.

Since 1948, there has been increasing recognition that these extra-sectoral factors have a significant influence on the health and well-being of individuals, directly impacting on an individual's ability to realise their right to health.[245] Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR),[246] read with General Comment 14, remains among the most comprehensive statements on the right to health and its content. The text of article 12 mirrors the wording of the WHO Constitution in outlining the right to health as 'the right of everyone to the enjoyment of the highest attainable standard of physical and mental health'. Sub-section 2 of the article outlines in greater detail the obligations of a state in fulfilling this right.[247] The framing of these obligations deviates from the SDOH approach adopted in the UDHR, focusing more on healthcare services, health outcomes and disease than on antecedents to good health such as housing, nutrition and education recognised in the UDHR. Yet General Comment 14 does capture these underlying determinants of health, stating:

> 'The Committee interprets the right to health, as defined in article 12.1, as an inclusive right extending not only to timely and appropriate health care but also to the *underlying determinants of health*, such as access to safe and potable water and adequate sanitation, an *adequate supply of safe food, nutrition* and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health'[248]

Further, the Comment explicitly acknowledges that though the text of article 12.1 is not as expansive as the WHO Constitution, its scope is intended to capture a broader definition which recognises the SDOH as the 'conditions in which people can lead a healthy life'.[249] Notwithstanding the adoption of this expanded conception of the right to health, the General Comment does contain caveats, acknowledging that a state cannot completely or fully ensure the good health of its citizens since illness may be the result of genetic factors or an individual's

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[245] Gostin op cit note 53, at 257.

[246] International Covenant on Economic, Social and Cultural Rights, Adopted and opened for signature, ratification and accession by General Assembly resolution 2200A (XXI) of 16 December 1966, entry into force 3 January 1976.

[247] Article 25, sub-section 2 of the WHO Constitution reads: 'The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:

> The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;
> The improvement of all aspects of environmental and industrial hygiene;
> The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
> The creation of conditions which would assure to all medical service and medical attention in the event of sickness.'

[248] General Comment 14 at para 11 (emphasis added).

[249] Ibid at para 4 states:

> 'On the contrary, the drafting history and the express wording of article 12.2 acknowledge that the right to health embraces a wide range of socio-economic factors that promote conditions in which people can lead a healthy life, and extends to the underlying determinants of health, such as food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions, and a healthy environment."

lifestyle.[250] The Comment also explicitly recognises the realisation of other rights (including socio-economic, civil and political rights) as an integral component for realising the right to health:

> 'The right to health is closely related to and dependent upon the realization of other human rights, as contained in the International Bill of Rights, including the rights to food, housing, work, education, human dignity, life, non-discrimination, equality, the prohibition against torture, privacy, access to information, and the freedoms of association, assembly and movement.'[251]

The Declaration of Alma Ata, which placed the right to health at the forefront of addressing global health inequities, focused on primary healthcare as a means to realise the right to health. However, in conceptualising the right to health and the role of policies, the Declaration of Alma Ata recognised that realisation of the right to health was contingent upon action from sectors outside the healthcare sector, stating:

> 'The Conference strongly reaffirms that health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of *many other social and economic sectors in addition to the health sector*.'[252]

Specifically, the Declaration recognised that economic and social development were required for the 'fullest attainment of health for all and [for] the reduction of the gap between the health status of the developing and developed countries'.[253]

In 1986, the Ottawa Charter for Health Promotion (the Ottawa Charter) built on this multi-sectoral approach and made it central to the realisation of the right to health, stating '[h]ealth is a positive concept emphasising social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but *goes beyond healthy lifestyles to well-being*.'[254] The Ottawa Charter went further, outlining in concrete terms 'prerequisites for health' which included many underlying determinants of health such as food, shelter, education and equity.[255] The Ottawa Charter specifically held these

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[250] Ibid at para 9: The notion of "the highest attainable standard of health" in article 12.1 takes into account both the individual's biological and socio-economic preconditions and a State's available resources. There are a number of aspects which cannot be addressed solely within the relationship between States and individuals; in particular, good health cannot be ensured by a State, nor can States provide protection against every possible cause of human ill health. Thus, genetic factors, individual susceptibility to ill health and the adoption of unhealthy or risky lifestyles may play an important role with respect to an individual's health. Consequently, the right to health must be understood as a right to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health.'

[251] Ibid at para 3.

[252] Declaration of Alma-Ata at para I (emphasis added).

[253] Ibid at para III.

[254] World Health Organisation, 'Ottawa Charter for Health Promotion: the 1st International Conference on Health Promotion, Ottawa, 1986', available at https://www.who.int/healthpromotion/conferences/previous/ottawa/en/, accessed 22 May 2020 (emphasis added).

[255] Ibid. The complete list of "Prerequisites for Health" are outlined as follows: 'The fundamental conditions and resources for health are: peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice, and equity. Improvement in health requires a secure foundation in these basic prerequisites'.

to be ‘the fundamental conditions and resources for health’ and went further to emphasise the role of SDOH and underlying determinants of health: ‘Political, economic, social, cultural, environmental, behavioural and biological factors can all favour health or be harmful to it’.[256]

(b) The right to health under population-specific treaties

Treaties specific to the rights of vulnerable populations have often adopted a narrower conceptualisation of the right to health. The Convention on the Elimination of All Forms of Discrimination Against Women,[257] which specifically applies to women's HR, outlines a state’s obligations regarding health under article 12 as consisting of the elimination of discrimination against women to ensure equal access to healthcare services for men and women.[258] Article 12 also provides for special protections for rural women to ensure that they have access to healthcare services, specifically antenatal care. Notably, in this instance, the obligation extends to include access to adequate nutrition during and after pregnancy, thus including a limited recognition of nutrition as an underlying determinant of health.

The Convention on the Rights of the Child[259] contains both obligations and entitlements in relation to the right to health, as well as the provision that some rights may be limited in the interests of public health.[260] Article 24 recognises the rights of children ‘to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health’, and specifically places an obligation on the state to ensure that children are provided with access to healthcare services, including treatment and preventative services.[261] Article 24 goes further than this, though: sub-article 2 requires states to ‘pursue full implementation’ of this right to health by, inter alia, providing healthcare and medical assistance as well as combatting disease and malnutrition.[262] Sub-article 2(e) acknowledges the

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[256] Ibid.

[257] Convention on the Elimination of All Forms of Discrimination against Women adopted by the United Nations General Assembly on 18 December 1979, entered into force on 3 September 1981. (CEDAW).

[258] Article 12 of CEDAW states: ‘1. States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning; 2. Notwithstanding the provisions of paragraph I of this article, States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation’.

[259] United Nations, ‘Convention on the Rights of the Child, adopted by General Assembly resolution 44/25 of 20 November 1989’, entered into force 2 September 1990 (CRC).

[260] See for example, articles 10, 13, 14 of the CRC op cit note 259 which allow for the restriction of certain rights such as the right to freedom of expression or religion ‘For the protection of national security or of public order (ordre public), or of public health or morals’.

[261] Article 24.1 of the CRC states:

> ‘States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.’

[262] Article 24.2 of the CRC states:

> ‘States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures:
>
> > To diminish infant and child mortality;
> >
> > To ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care;

role of some underlying determinants of health such as nutrition, hygiene and sanitation, although it only imposes obligations on states to educate parents and children, rather than mandating states to address these determinants as part of the protection and realisation of the right to health. Article 27 recognises a right to an adequate standard of living and, in the context of this obligation, imposes a duty on states to provide assistance to parents with respect to the provision of nutrition, clothing and housing – thus further recognising the role of underlying determinants of health.[263]

The integral relationship between NCDs and the right to health was recognised in the 2011 Moscow Declaration,[264] which acknowledged that 'the right of everyone to the enjoyment of the highest attainable standards of physical and mental health cannot be achieved without greater measures at global and national levels to prevent and control NCDs'.[265] The Moscow Declaration identified a range of actions required to prevent and control NCDs, including a number that exist outside the healthcare sector such as legislation, policies and health promotion.[266] In this way, the Declaration explicitly tied the prevention of NCDs through means outside of the healthcare sector directly to the fulfilment of the right to health. A fuller discussion of the rights-based approach to NCDs is contained in Chapter 2 and will not be reiterated here.

As outlined above, the various paradigms and definitions of the right to health contained in international law show that there is a basis for the right to health to include obligations, duties

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> To combat disease and malnutrition, including within the framework of primary health care, through, inter alia, the application of readily available technology and through the provision of adequate nutritious foods and clean drinking-water, taking into consideration the dangers and risks of environmental pollution;
> To ensure appropriate pre-natal and post-natal health care for mothers;
> To ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of accidents;
> To develop preventive health care, guidance for parents and family planning education and services.'

[263] Article 27.3 of the CRC which reads, 'States Parties, in accordance with national conditions and within their means, shall take appropriate measures to assist parents and others responsible for the child to implement this right and shall in case of need provide material assistance and support programmes, particularly with regard to nutrition, clothing and housing.'

[264] First Global Ministerial Conference on Healthy Lifestyles and Noncommunicable Disease Control Moscow, 28-29 April 2011, 'The Moscow Declaration' available at https://www.who.int/nmh/events/moscow_ncds_2011/conference_documents/moscow_declaration_en.pdf?ua=1 (the Moscow Declaration).

[265] Ibid.

[266] The Moscow Declaration endorses actions such as 'Implementing cost-effective policies, such as fiscal policies, regulations and other measures to reduce common risk factors such as tobacco use, unhealthy diet, physical inactivity and the harmful use of alcohol'. The Moscow Declaration at para V states:

> 'Emphasize that prevention and control of NCDs requires leadership at all levels, and a wide range of multi-level, multi-sectoral measures aimed at the full spectrum of NCD determinants (from individual-level to structural) to create the necessary conditions for leading healthy lives. This includes promoting and supporting healthy lifestyles and choices, relevant legislation and policies; preventing and detecting disease at the earliest possible moment to minimize suffering and reduce costs; and providing patients with the best possible integrated health care throughout the life cycle including empowerment, rehabilitation and palliation.'

and content that extend beyond access to healthcare services and encompass the protection and realisation of the underlying determinants of health. Many international instruments recognise that the underlying determinants of nutrition, shelter and sanitation are central to the realisation of the right to health. Consequently, a broader approach to realising and protecting the right to health can take cognisance of, and involve, the protection and realisation of underlying determinants such as nutrition and sanitation.

(c) The scope of the right to health under regional instruments

At a regional level, there is similar discussion around the right to health and, in particular, the development of a scope that extends beyond access to healthcare despite the narrower text contained in the instruments. The African Charter on Human and Peoples' Rights (the African Charter),[267] recognises the right to health in Article 16 as the right of every individual 'to enjoy the best attainable state of physical and mental health'.[268] The article outlines the specific obligations states have with regard to the fulfilment and realisation of the right to health, stating: 'State parties to the present Charter shall take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick'.[269]

Despite expressly outlining the core obligations in relation to medical attention, subsequent interpretation of the article has seen the text imbued with a broader meaning. In *Social and Economic Rights Action Centre and another v Nigeria*,[270] the Commission recognised a right to food as being implicitly contained in both article 4 (the right to life) and article 16 (the right to health) of the African Charter.[271] The Commission explicitly recognised a conceptualisation of the right to health contingent upon the enjoyment of other rights:

> 'While the right to food is not specifically enumerated in the African Charter, it is implicit in such provisions as the right to life (art.4), the right to health (art. 16) and the right to economic, social and cultural development (art. 22) ... It is undeniable that food is central to the enjoyment of such other rights as health, education, work and political participation.'[272]

This solidified the content of article 16 as expanding beyond healthcare to include underlying determinants of health – specifically nutrition. Notably, the *SERAC* decision also underscored the enforceability of the right against the actions of private individuals where those actions could result in the infringement of rights under the African Charter.

In the Principles and Guidelines on the implementation of economic, social and cultural rights in the African Charter[273] (the Nairobi Principles), the African Commission included determinants of health, including safe water, adequate food and healthy environmental

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[267] African (Banjul) Charter on Human and Peoples' Rights, adopted 27 June 1981, OAU Doc. CAB/LEG/67/3 rev. 5, 21 I.L.M. 58 (1982), entered into force 21 October 1986.
[268] Article 16 of the African Charter.
[269] Article 16.2 of the African Charter.
[270] *African Commission on Human and Peoples Rights, Communication 155/96, the Social and Economic Rights Action Centre & Centre for Economic and Social Rights v Nigeria*, Fifteenth Annual Activity Report (*SERAC*)
[271] Ibid at 9.
[272] Ibid at 10.
[273] African Commission on Human and Peoples' Rights 'Principles and Guidelines on the Interpretation of Economic, Social and Cultural Rights in the African Charter on Human and Peoples' Rights' (2010) available at https://www.achpr.org/public/Document/file/English/achpr_instr_guide_draft_esc_rights_eng.pdf (accessed 27 October 2022)

conditions within the right to health alongside a right to access healthcare.[274] As part of the minimm core obligations under the right to health, the State is obliged to take measures to prevent, treat and control epidemic diseases.[275]

The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (the Protocol)[276] provides special protections to women, specifically to protect women against discrimination. Article XIV of the Protocol contains a right to health, specifically related to sexual and reproductive health.[277] The scope of the rights protected under this article are explicitly related to reproductive rights and care, including access to contraceptives, the right to be protected against sexually transmitted infections and the right to family planning education. Under Article XIV.2, states are required to provide 'adequate, affordable and accessible health services' and to provide health and nutritional services to women during pregnancy and breast-feeding.[278] The Protocol also requires states to take action to curb 'harmful practices', including practices which, inter alia, negatively affect a women's rights to health, dignity and physical integrity, thus extending the duty on states beyond reproductive health as defined in Article XIV.[279]

Under article 14 of the African Charter on the Rights and Welfare of the Child (African Children's Charter),[280] all children have the right to enjoy the best attainable state of physical, mental and spiritual health. Article 14.2 outlines a state's obligations under this right and includes specific measures to protect this right. Specifically, states are required to 'to ensure the provision of necessary medical assistance and health care to all children', and further, as a part of the fulfilment of the right to health, to 'ensure the provision of adequate nutrition and safe drinking water' as an underlying determinant of health.[281] In addition, states are required to support partners and provide assistance in respect of 'nutrition, health, education, clothing and housing'.[282]

The African Committee of Experts on the Rights and Welfare of the Child (ACERWC) has developed an Agenda for Children 2040 (the 2040 Agenda) which includes aspirations for children. Aspiration 4 includes that every child has a healthy childhood and Aspiration 5 is that "Every child grows up well-nourished and with access to the basic necessities of life".[283] In

[274] Ibid at para 60.
[275] Ibid at para 67.
[276] Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa, adopted on 11 July 2003, entered into force 25 November 2005 (the Maputo Protocol).
[277] Article XIV of the Maputo Protocol.
[278] Article XIV.2 of the Maputo Protocol.
[279] Harmful practices are defined in the Protocol as 'all behaviour, attitudes and/or practices which negatively affect the fundamental rights of women and girls, such as their right to life, health, dignity, education and physical integrity'.
[280] African Charter on the Rights and Welfare of the Child, adopted July 1990, entered into force on 29 November, 1999.
[281] Article 14 of the African Children's Charter.
[282] Article 20 of the African Children's Charter.
[283] African Committee of Experts on the Rights and Welfare of the Child 'Agenda for Children 2040' (2016) at 11.

both aspirations childhood nutrition and access to services are incorporated.[284] However, Aspiration 5 focusses almost exclusively on undernutrition.[285]

Though the recognition of the underlying determinants of health is more limited within regional instruments, the infrastructure of the African Charter and other population-specific conventions do recognise the right to health as encompassing a broader array of obligations than merely an obligation to provide access to healthcare and medical services.

IV. RIGHT TO HEALTH UNDER SOUTH AFRICAN LAW: CONSTITUTIONAL PROVISIONS

Under both international and regional law, there is recognition that the right to health comprises more than merely medical assistance and access to healthcare services. Although the degree to which underlying determinants of health are afforded protection varies under the various instruments discussed above, there is broad acknowledgment that these determinants remain a part of the realisation of the right to health.

The right to health under the South African Constitution is most often discussed in the context of section 27(1)(a), which provides that everyone has a right to access adequate healthcare subject to progressive realisation and the resources of the state. Health-related rights are, however, given further recognition in other sections. For example, sub-section 27(3) provides an unqualified right to emergency medical treatment. The right to bodily integrity under section 12(2) entitles all to the right to make decisions concerning reproductive health and imposes the requirement of informed consent for medical and scientific experiments.[286] There are also specific rights pertaining to medical treatment for children and prisoners (under sections 28 and 35 respectively) which are not subject to progressive realisation.

Beyond the scope of these rights explicitly linked to healthcare and medical treatment, there are further rights which could be invoked to protect a broader right to health. Section 24 provides that every South African is entitled to a healthy environment, which is broadly defined. The right has limited enforceable and justiciable elements, however, as outlined in sub-section 24(b), which stipulates a clearer link to promoting sustainability and preventing environmental degradation.[287] In addition, section 27(1) encompasses not just a right to access healthcare services, but also entitlements related to sufficient food and water, social security, and electricity (which have been previously discussed as underlying determinants of health).[288]

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[284] Ibid at 26.

[285] Ibid at 28.

[286] Section 12(2) of the Constitution provides:

> 'Everyone has the right to bodily and psychological integrity, which includes the right
> a. to make decisions concerning reproduction;
> b. to security in and control over their body; and
> c. not to be subjected to medical or scientific experiments without their informed consent."

[287] Section 24 of the Constitution.

[288] Section 27(1) of the Constitution reads:

> "Everyone has the right to have access to -
> a. health care services, including reproductive health care;
> b. sufficient food and water; and

The framing of section 27(1)(a) as a right to healthcare is narrower than a right to health. Some have suggested that the ambit of the right is framed as healthcare due to the justiciable nature of the socio-economic rights and the inability of a state to guarantee a right to health.[289] Yet often these constitutional rights to healthcare are conflated with, or considered analogues of, a right to health as it is typically understood under international law or other jurisdictions. Though substantial portions of jurisprudence focus on the healthcare system, there is a need to delineate the true ambit of the healthcare rights outside the domain of the healthcare system.

The question arisees then as to whether these additional constitutional entitlements serve to protect a broader right to health and, if so, to what extent. Scholarship on the question of the scope of the right to health protected under the Bill of Rights has largely focused on access to healthcare and bio-medical interventions, such as issues around the affordability of medicines. Discussions on the right to health as it applies outside the healthcare section have been more limited. For example, Bilchitz has suggested that section 27 may be interpreted as creating a composite right to health, though the discussion is limited to the broad proposition.[290]

In 2005, Pieterse argued that there is no explicit analogue for the right to health within the Bill of Rights, but the scope of the right to health enshrined in the Constitution can be gleaned from reading various health-related provisions together.[291] Arguably, this approach would be in keeping with the provisions of section 39(2), which requires the courts to consider international law when interpreting the Bill of Rights.

In considering where protection and entitlements for the underlying determinants of health may be located within the Bill of Rights, Pieterse suggests that section 24 could provide a basis for both a right to occupational health and rights for a 'variety of other non-medicinal, health-conducive social goods'.[292] Pieterse goes further, arguing that many of the underlying determinants of health can be located within specific rights:

> 'With the exception of a right to sanitation (which I would argue nevertheless finds residual protection under s 24(a)), rights to most nonmedicinal, health-conducive social goods are also enshrined separately by the Bill of Rights. A right to have access to adequate housing is guaranteed by s 26, whereas ss 27(1)(b) and (c) award rights to have access to sufficient food and water and to social security respectively. Children's rights to shelter and basic social

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c. social security, including, if they are unable to support themselves and their dependants, appropriate social assistance.'

[289] David Bilchitz 'Health' in Matthew Chaskalson and Stu Woolman (eds.) *Constitutional Law of South Africa* 2 ed (2013) at 56A–5.

[290] Ibid at 56A–5

[291] Marius Pieterse 'A Benefit-Focused Analysis Of Constitutional Health Rights' (2005), unpublished dissertation, University of the Witwatersrand, Johannesburg at 59 reads:

> 'There is no single provision in the Constitution that simultaneously protects all aspects of the right to "the enjoyment of the highest attainable standard of physical and mental health". Rather, chapter 2 of the Constitution contains several scattered provisions aimed at promoting the realisation of the right to health, which ought to be read together when ascertaining the extent of health-related protection awarded by the Bill of Rights.'

[292] Ibid at 66.

> services find further protection under s 28(1)(c), whereas s 29(1)(a) confers a right to basic education'[293]

This proposition provides a valuable starting point to discuss the scope and extent of the protection of the right to health afforded by the Bill of Rights. Yet in the fifteen years following Pieterse's suggestion, case law regarding the protection of the right to health has often not read these other rights in terms of a composite right to health per se, but has frequently expanded the ambit of the section 27(1)(a) protection. For this reason, it is worth discussing the existing scope of the right to healthcare and the extent to which it protects underlying determinants before considering the role of the other rights discussed above.

V. THE DEVELOPMENT OF RIGHT TO HEALTH JURISPRUDENCE IN SOUTH AFRICA

(a) Defining the content of the right to healthcare

When discussing the South African right to health, the natural starting point remains *Soobramoney*,[294] the first Constitutional Court case to pronounce on the health-related rights contained in section 27. Though the case deals with the treatment of a chronic disease through biomedical intervention (and thus the core of the provision of healthcare services as contemplated within section 27(1)(a)), there are several statements that paint a comprehensive view of how the right to healthcare should be understood within the context of the broader landscape of health, and how its enforcement should be contextualised within the broader public's health and access to healthcare services.

At the outset, Chaskalson P frames the rights at issue in the case within the Preamble of the Constitution, stating that the rights under the Bill of Rights reflect the broader constitutional commitment to 'improve the quality of life of all citizens and free the potential of each person'.[295] In *Soobramoney*, the rights contained in the Bill of Rights, and specifically those in section 27, are shown to be integrally linked to the fulfilment of this commitment to improving the quality of life.[296] This link is made explicit when Chaskalson P states:

> 'There are also those who need access to housing, food and water, employment opportunities, and social security. These too are aspects of the right to ". . . human life: the right to live as a human being, to be part of a broader community, to share in the experience of humanity."'[297]

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[293] Ibid at 67.

[294] *Soobramoney v Minister of Health (Kwazulu-Natal)* 1997 (12) BCLR 1696.

[295] Ibid at para 9 which reads:

> 'The constitutional commitment to address these conditions is expressed in the preamble which, after giving recognition to the injustices of the past, states:
> "We therefore, through our freely elected representatives, adopt this Constitution as the supreme law of the Republic so as to –
> Heal the divisions of the past and establish a society based on democratic values, social justice and fundamental human rights; …
> Improve the quality of life of all citizens and free the potential of each person".
> This commitment is also reflected in various provisions of the bill of rights and in particular in sections 26 and 27 which deal with housing, health care, food, water and social security.'

[296] Ibid at para 31.

[297] Ibid at para 31.

Despite the narrower wording of section 27(1)(a), this interpretation of the socio-economic rights being read together to create a type of 'right to dignified life' aligns with both the underlying determinants of health framing of the right to health under international HR law, and the type of interrelationship Pieterse suggested in his thesis.

Further on, Chaskalson P outlines the need for a more expansive interpretation when adopting a purposive reading of the Bill of Rights:

> 'The purposive approach will often be one which calls for a generous interpretation to be given to a right to ensure that individuals secure the full protection of the bill of rights, but this is not always the case, and the context may indicate that in order to give effect to the purpose of a particular provision "a narrower or specific meaning" should be given to it.'[298]

This context, in *Soobramoney*, included the 'other provisions of the Constitution itself and, in particular, the provisions of the [Bill of Rights] of which [they are] part'.[299] One manner in which this may be understood in the context of a determinants-based approach to the right to health is to underscore how the content of particular rights may be informed by each other. In other words, a right to healthcare may be imbued with content related to another right (food or water, for instance), where that content may have a bearing on the realisation of that initial right and vice versa.

The links between the underlying determinants of health and the right to health are made explicit in Sach's minority. In discussing the interdependence of both rights and utilisation of the healthcare system, he states:

> 'Health care rights by their very nature have to be considered not only in a traditional legal context structured around the ideas of human autonomy but in a new analytical framework based on the notion of human interdependence. A healthy life depends upon social interdependence: the quality of air, water, and sanitation which the state maintains for the public good; the quality of one's caring relationships, which are highly correlated to health; as well as the quality of health care and support furnished officially by medical institutions and provided informally by family, friends, and the community.'[300]

While this statement appears in a minority judgment, it nonetheless recognises that the provision of healthcare services is only one determinant of an individual's health, while other determinants outside the healthcare system – which may find protection within other rights in the Bill of Rights – have a significant impact on one's ability to lead a healthy life as contemplated in the Preamble of the Constitution. Though not expressly linked to the right to healthcare, there is nevertheless a clear endorsement that the entitlement to lead a healthy life is predicated not solely on the provision of healthcare services, but also on the protection and fulfilment of the antecedents to good health. This is perhaps a reasonable elaboration on the links between the commitment to improving quality of life and socio-economic rights that Chaskalson P outlined in the majority.

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[298] Ibid at para 17

[299] Ibid at para 16 referring to *S v Makwanyane and Another* 1995 (4) BCLR 665 (CC) at para 10.

[300] *Soobramoney* supra note 294 at para 54.

It is also worth noting the parting observation offered in Madala J's concurring judgment, which ruminates on a solution lying outside the domain of healthcare services. Madala J suggests:

> 'Perhaps a solution might be to embark upon a massive education campaign to inform the citizens generally about the causes of renal failure, hypertension and diabetes and the diet which persons afflicted by renal failure could resort to in order to prolong their life expectancy.'[301]

This observation, though not immediately relevant to the case of the applicant, alludes to the idea that prevention of disease may very well be a better and more sustainable solution than focusing on treatment alone. This is the contention underpinning the argument of the present Chapter: that the content of the right to healthcare under section 27(1)(a) includes the prevention of disease, even where this prevention may be by way of interventions that lie outside the healthcare system and pharmaceutical interventions – for example, in changes to diet and knowledge.

The *Treatment Action Campaign*[302] case was different to *Soobramoney* in three key areas. It concerned: (1) the prevention of a disease through use of a biomedical intervention, Nevirapine; (2) the disease being prevented, HIV, was considered 'the most important challenge facing South Africa since the birth of our new democracy'; and, (3) the case was brought in the public interest rather than by an individual seeking to vindicate their rights. It is perhaps a direct result of these features that the *TAC* case provides far less detail in terms of the content of section 27(1)(b) and its application.

From the outset, the rights and legal question at issue were framed in terms of section 27 and 28 of the Constitution – that is, 'whether government is constitutionally obliged and had to be ordered forthwith to plan and implement an effective, comprehensive and progressive programme for the prevention of mother-to-child transmission of HIV throughout the country'.[303] In answering this question, the Court implicitly included a set of interventions aimed at preventing disease within the ambit of 'healthcare services' under section 27.[304] It is pertinent to note that the judgment arose from a context in which there was a comprehensive policy in place to roll out the drug, but the policy was not being implemented. In this regard, the findings made by the Court then extended not only the preventative services but also the features needed to implement the intervention.

> 'If, as we have held, it was not reasonable to restrict the use of Nevirapine to the research and training sites, the policy as a whole will have to be reviewed. Hospitals and clinics that have testing and counselling facilities should be able to prescribe nevirapine where that is medically indicated. The training of counsellors ought now to include training for counselling on the use of nevirapine. As previously indicated, this is not a complex task and it should not be difficult to equip existing counsellors with the necessary additional knowledge. In addition, government will need to take reasonable measures to extend the testing and counselling facilities to hospitals and clinics throughout the public health sector beyond the test sites to

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301 Ibid at para 49.
302 *Minister of Health and Others v Treatment Action Campaign and Others (No 2)* 2002 (10) BCLR 1033 *(TAC)*.
303 Ibid at para 5.
304 Ibid at para 25.

> facilitate and expedite the use of nevirapine for the purpose of reducing the risk of mother-to-child transmission of HIV.'[305]

In making its findings on the reasonableness of government's policy, the Court further expanded the ambit of healthcare services to include testing and counselling as necessary antecedents to prescribing Nevirapine, ensuring the drug could be used to reduce the risk of transmission.

Due to the impact of Nevirapine on young children, the decision in *Grootboom*[306] was of particular relevance to the state's obligations to provide the drug and prevent HIV transmission, especially given the non-implementation of the policy resulting in access for a limited few to the exclusion of the majority.[307] In this regard, the Court stressed that since mothers mainly depend on state provision of healthcare services (in the form of public hospitals) there was an urgency to their needs being met:

> 'The provision of a single dose of nevirapine to mother and child for the purpose of protecting the child against the transmission of HIV is, as far as the children are concerned, essential. Their needs are "most urgent" and their inability to have access to nevirapine profoundly affects their ability to enjoy all rights to which they are entitled. Their rights are "most in peril" as a result of the policy that has been adopted and are most affected by a rigid and inflexible policy that excludes them from having access to nevirapine. The state is obliged to ensure that children are accorded the protection contemplated by section 28 that arises when the implementation of the right to parental or family care is lacking.'[308]

In *Minister of Health, Western Cape v Goliath*,[309] the High Court had to consider the definition of healthcare services, as per the definition of the Health Act of 2003, and decide on whether to order the mandatory isolation of patients with XDR-TB.[310] The definition adopted under the Act expressly references section 27 and the accompanying rights to healthcare services, reproductive healthcare and emergency medical treatment.[311] The Court adopted a purposive

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[305] Ibid at para 91.

[306] *Government of the Republic of South Africa and Others v Grootboom and Others* 2000 (11) BCLR 1169.

[307] Ibid at para 68:

> 'In *Grootboom* this Court held that
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> > "[t]o be reasonable, measures cannot leave out of account the degree and extent of the denial of the right they endeavour to realise. Those whose needs are the most urgent and whose ability to enjoy all rights therefore is most in peril, must not be ignored by the measures aimed at achieving realisation of the right.' … A programme for the realisation of socio-economic rights must
>
> "be balanced and flexible and make appropriate provision for attention to . . . crises and to short, medium and long term needs. A programme that excludes a significant segment of society cannot be said to be reasonable."

[308] Ibid at paras 78-9.

[309] *Minister of Health, Western Cape v Goliath & others* 2009 (2) SA 248 (C).

[310] Ibid at para 52.

[311] Specifically the definition under interpretation read:

> 'Health services' is defined in s 1 of the 2003 Act as –
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> '(a) health care services, including reproductive health care and emergency medical treatment, contemplated in section 27 of the Constitution;
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> (b) basic nutrition and basic health care services contemplated in section 28(1)(c) of the Constitution;
>
> (c) medical treatment contemplated in section 35(2)(e) of the Constitution; and
>
> (d) municipal health services.'

interpretation of the definition which was read to include 'involuntary isolation of patients with infectious diseases at a state-funded healthcare facility'.[312]

It should be noted at this stage that *Goliath* has been subject to criticism, not only for its section 36 limitations analysis but even for its definition of healthcare services, with some authors contending that isolation serves the purpose of infection control and does not constitute the provision of healthcare services.[313] This critique, however, also highlights an additional shortcoming of the *Goliath* decision that renders this definitional challenge of negligible impact – namely, the failure to situate the broader public health crisis that *Goliath* responds to within the positive obligations emanating from section 27(1)(a). Pieterse & Hassim contend that the Extensively Drug-Resistant Tuberculosis (XDR-TB) crisis in South Africa at that time implicated two Constitutional rights:

> 'The right to have access to health care services in s 27(1)(a) of the Constitution obliges the state, in s 27(2), to take reasonable legislative and other measures to achieve its progressive realization, within its available resources. Section 24(a) of the Constitution entitles all citizens to "an environment that is not harmful to their health or well-being", whereas s 7(2) requires of the state to "respect, protect, promote and fulfil" these rights, alongside all the other rights guaranteed by the Bill of Rights (including the right to freedom and security of the person).'[314]

Though the authors lay blame for the pandemic on the state for failure to deliver on its obligations, these obligations are framed as including a variety of NPIs, including contract tracing, testing, education and 'efforts to improve the living conditions of those susceptible to the disease' – thus including a range of public health interventions within the ambit of section 27(1)(a) read with section 24(a). There thus appears to be some consensus around the view that section 27(1)(a) does encompass epidemic response interventions aimed at protecting public health, even where these may not per se constitute the provision of healthcare services to a particular individual.

(b) Application of section 27(1)(a) to non-pharmaceutical interventions

As Pieterse & Hassim note, the NPIs ordinarily adopted in an epidemic response do not serve to provide healthcare to those targeted but to reduce the spread of disease.[315] The relationship these interventions have with the right to health is not neatly framed as an individual applicant subject to the intervention, but rather in terms of protecting the health and well-being of the broader public. The question is whether these interventions serve only a public health objective or also work to fulfil and protect the right to health.

This brings us to the consideration of the broader public's right to health as a facet of the section 27(1)(a) obligations. One component of South Africa's jurisprudence on the right to health which remains unusual is the collectivist interpretation and enforcement adopted by the Constitutional Court. In many jurisdictions with justiciable rights to health (particularly in South America), the increasing judicialisation of the right to health has resulted in healthcare

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[312] *Goliath* supra note 309 at para 57.
[313] Marius Pieterse and Adila Hassim, 'Placing Human Rights at the Centre of Public Health : A Critique of Minister of Health, Western Cape v Goliath' (2009) 126 *South African Law Journal* 231 at 243.
[314] Ibid at 244.
[315] Ibid.

priorities being dictated by the judiciary and individual courts cases.[316] Though there are debates and differing accounts of the true impact of this judicialisation on equity and the healthcare, most have viewed the phenomenon as increasing the individualisation and pharmaceuticalisation of healthcare services, in many instances skewing resources to the few individuals vindicating rights through the court system rather than collective society.[317]

This is relevant in two respects: the content of the right to health being defined narrowly through provision and access to biomedical interventions; and, secondly, consideration of the public's right to health. The former has been discussed above, and it has been demonstrated that despite the narrower wording of section 27(1)(a), the South African entitlement goes beyond the provision of healthcare services to include preventative measures. This section will canvass the latter, considering whether interventions that seek to protect the broad goal of public health can find protection and support within a right to health framework.

The South African approach has resisted this trend of individualistic interpretations of the right to healthcare.[318] This can largely be attributed to the foundations of collectivist interpretation adopted in early cases such as *Soobramoney*[319] and *TAC*.[320] The collectivist interpretation in these cases provides a basis upon which one can understand the content of the right to healthcare not simply in terms of individuals seeking to enforce the right, but as containing entitlements owed to the broader community and public. This is also related to the protection of the broader societal entitlement to access healthcare which has been interpreted as including preventative measures. Before elaborating the scope of this so-called 'right to

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[316] Luciana Souza d'Ávila, Eli Iola Gurgel Andrade, and Fernando Mussa Abujamra Aith 'Judicialization of Health in Brazil and Colombia: A Discussion in Light of the New Latin American Constitutionalism' (2020) 29 *Saúde e Sociedade*; Everaldo Lamprea 'The Judicialization of Health Care: A Global South Perspective' (2017) 13 *Annual Review of Law and Social Science* 431.

[317] This debate in not directly relevant to the arguments and discussion advanced in this section and thus, is only noted insofar as it presents a point of departure to understand the significance of a collectivist interpretation and enforcement of rights. However, should the reader wish to understand the impacts of judicialization of healthcare and the debates concerning its effect of equity, the issues are discussed comprehensively in Tatiana S. Andia and Everaldo Lamprea 'Is the Judicialization of Health Care Bad for Equity? A Scoping Review' (2019) 18 *International Journal for Equity in Health* 61; João Biehl, Mariana P. Socal, Varun Gauri et al 'Judicialization 2.0: Understanding Right-to-Health Litigation in Real Time' (2019) 14 *Global Public Health* 190; João Biehl, Mariana P. Socal, and Joseph J. Amon 'The Judicialization of Health and the Quest for State Accountability: Evidence from 1,262 Lawsuits for Access to Medicines in Southern Brazil' (2016) 18 *Health and Human Rights Journal*.

[318] This exceptionalism of South Africa in the trend of the Global South is investigated more comprehensively in Kaushik Sunder Rajan 'Just Health?: Law, Constitutionalism and Postcolonial Dis-ease' Draft paper for Wish Seminar, *WISER*, 7 September 2020 available at https://wiser.wits.ac.za/system/files/seminar/Rajan2020.pdf, accessed 30 June 2021. Rajan notes:

> 'South Africa has emerged as an exemplary locale for the manifestation and shaping of this phenomenon, in ways that have exceeded mere contractual dispute in order to adjudicate fundamental ethical, moral or constitutional principles, often taking recourse to discourses of rights. The judicialization of health is part of a more general contemporary global Southern phenomenon of the judicialization of politics.'

As mentioned above, my concern with the collectivist enforcement of the right to health is not in its relation to the concepts of judicialization of the right to health and the healthcare system more broadly, but in how it can inform the content of the right to health and delineate a scope within this for a sort of right to 'public health'. For this reason, the topic of judicialization of healthcare more broadly is not discussed in this chapter.

[319] *Soobramoney* supra note 294.

[320] *TAC* supra note 302.

public health', it is necessary to unpack the jurisprudence which establishes this collectivist approach to the right to health.

In this regard, *Soobramoney* serves once again as a natural starting point. As a case concerning the enforcement of an individual's right to dialysis treatment, the Court may have elected to enforce that right as an entitlement owed to the applicant alone, or to the group of individuals in the same medical position as the applicant. Instead, the Court elected to balance the right of the applicant and those in his position to healthcare against the right to healthcare of broader society. This position was articulated by Chaskalson P, who considered the competing interests at stake in terms of the impact that the provision of the dialysis treatment could have on the provision of other healthcare services – or even services outside the healthcare sector.[321] This was once again considered even more expressly within the discussion of resource constraints:

> 'Unfortunately, this is true not only of the appellant but of many others who need access to renal dialysis units or to other health services. There are also those who need access to housing, food and water, employment opportunities, and social security. These too are aspects of the right to ". . . human life: the right to live as a human being, to be part of a broader community, to share in the experience of humanity." The State has to manage its limited resources in order to address all these claims. There will be times when this requires it to adopt a holistic approach to the larger needs of society rather than to focus on the specific needs of particular individuals within society.' [322]

Though this is framed in terms of resource constraints, it is worth noting that in his concurring judgment, Sachs J draws out the collectivist interpretation beyond this. While initially Sachs recognises the integral role of rationing to the protection, promotion and realisation of HR,[323] he expands the concept to explicitly frame rights as being collectively held, shared entitlements. A court's role is thus not only to limit rights in resource constrained settings, but to support action which enables the greatest and most effective enjoyment of rights:

> 'Traditional rights analyses accordingly have to be adapted so as to take account of the special problems created by the need to provide a broad framework of constitutional principles governing the right of access to scarce resources and to adjudicate between competing rights bearers. When rights by their very nature are shared and inter-dependent, striking appropriate balances between the equally valid entitlements or expectations of a multitude of claimants should not be seen as imposing limits on those rights (which would then have to be justified

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[321] *Soobramoney* supra note 294 para 28 which reads:

> 'If all the persons in South Africa who suffer from chronic renal failure were to be provided with dialysis treatment – and many of them, as the appellant does, would require treatment three times a week – the cost of doing so would make substantial inroads into the health budget. And if this principle were to be applied to all patients claiming access to expensive medical treatment or expensive drugs, the health budget would have to be dramatically increased to the prejudice of other needs which the State has to meet.' (emphasis added)

[322] Ibid at para 31.

[323] Ibid at para 52-4 which in relevant part reads:

> 'In a case such as the present which engages our compassion to the full, I feel it necessary to underline the fact that Chaskalson P's judgment, as I understand it, does not merely "toll the bell of lack of resources". In all the open and democratic societies based upon dignity, freedom and equality with which I am familiar, the rationing of access to life-prolonging resources is regarded as integral to, rather than incompatible with, a human rights approach to health care….The inescapable fact is that if governments were unable to confer any benefit on any person unless it conferred an identical benefit on all, the only viable option would be to confer no benefit on anybody'

> in terms of section 36), but as defining the circumstances in which the rights may most fairly and effectively be enjoyed.'[324]

The court's duty in relation to these rights, and thus the content of the entitlements of these rights, are not owed exclusively to those seeking to vindicate their rights in an immediate court case. They are instead a diffuse, collectively held entitlement. Actions must therefore aim to protect that more collective entitlement – a right to public health, so to speak, rather than the rights of those concretely before the court.

This framing of the individual entitlements under section 27 against a broader societal entitlement to access health was reiterated in *TAC,* which referred to *Soobramoney* with approval in the context of the establishment of a minimum core, stating:

> 'It should be borne in mind that in dealing with such matters the courts are not institutionally equipped to make the wide-ranging factual and political enquiries necessary … for deciding how public revenues should most effectively be spent. There are many pressing demands on the public purse. As was said in Soobramoney: "The State has to manage its limited resources in order to address all these claims. There will be times when this requires it to *adopt a holistic approach to the larger needs of society rather than to focus on the specific needs of particular individuals* within society."' [325]

In *TAC*, the Court considered the flipside of this issue, noting the substantial effects the HIV pandemic could have on the achievement of other rights while acknowledging, as in *Soobramoney,* that government also faces demands to meet obligations to access, inter alia, education, housing, water and food.[326]

(i) The ambit of section 27(1)(a) in relation to non-pharmaceutical interventions

Consequently, the foundation for a collectivist interpretation of the right to healthcare is entrenched in the most foundational of section 27(1)(a) jurisprudence. The issue of the pharmaceuticalisation of the right to health provides a further, useful contrast in understanding the content of section 27(1)(a). Although pharmaceutical interventions are included in the ambit of section 27(1)(a), there has also been consideration of a more holistic definition within the jurisprudence. Specifically, as has been discussed above, preventative measures are part of the right to healthcare. However, to fully understand the application of this right to NCD prevention measures, there is a need to assess the ambit of this content outside the healthcare section. To this end, the next section will consider the scope of the more holistic definition as illustrated by the extent to which the right to healthcare encompasses NPIs that lie outside the healthcare sector.

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[324] Ibid at para 54.
[325] *TAC* supra note 302 at para 37 (emphasis added).
[326] Ibid at para 94 which states:

> 'We are also conscious of the daunting problems confronting government as a result of the pandemic. And besides the pandemic, the state faces huge demands in relation to access to education, land, housing, health care, food, water and social security. These are the socio-economic rights entrenched in the Constitution, and the state is obliged to take reasonable legislative and other measures within its available resources to achieve the progressive realisation of each of them. In the light of our history this is an extraordinarily difficult task. Nonetheless it is an obligation imposed on the state by the Constitution.'

Lee v Minister of Correctional Services[327] offers an interesting point of departure to the more expansive reading of section 27(1)(a) by providing alternative rights to support the adoption of NPIs in preventing disease. Here, the applicant contended that government's omissions had violated his rights to human dignity (section 10), life (section 11), freedom and security of person (section 12(1)), and the composite set of detainee entitlements under section 35(2)(e).[328] However, in framing the matter, the amici also invoke section 27(1)(b) in respect of the provision of Tuberculosis (TB) treatment.[329]

In considering the content of section 35(2)(e) and the state's duties to provide medical treatment to prisoners, the Court read this obligation with the state's duty to provide conditions consistent with human dignity, tying healthcare obligations to the right to dignity:

> 'That there is a duty on Correctional Services authorities to provide adequate health care services, as part of the constitutional right of all prisoners to "conditions of detention that are consistent with human dignity" is beyond dispute. It is not in dispute that in relation to Pollsmoor the responsible authorities were aware that there was an appreciable risk of infection and contagion of TB in crowded living circumstances. Being aware of that risk they had a duty to take reasonable measures to reduce the risk of contagion'.[330]

What is of great import for the purposes of this discussion is the question of what constitutes 'reasonable measures' to discharge this duty. The case concerned the spread of TB, the prevention measures of which remain largely NPIs. In this case, both courts accepted that 'reasonable measures' would consist of a series of NPIs, including the regular screening of inmates for TB, quarantining infected inmates or those at risk of infection, and providing adequate nutrition.[331] Though some measures such as medical examinations fall neatly within the ambit of healthcare services, others such as isolation and the provision of adequate nutrition extend beyond the healthcare sector.

(ii) Section 27(1)(a) and NCD prevention

The application of section 27(1)(a) to NPIs within the context of NCDs is found in the case law which challenged the constitutionality of the advertising ban on tobacco products.[332] British American Tobacco (Pty) Ltd (BAT) challenged the constitutionality of the Tobacco Products Control Amendment Act 63 of 2008, specifically the sections which prohibited the advertising of tobacco products on the grounds that the ban unjustifiably limited BAT's right to freedom

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[327] *Lee v Minister of Correctional Services* 2013 (2) BCLR 129 (CC).
[328] Ibid at para 13.
[329] Ibid at para 26.
[330] Ibid at para 59.
[331] Ibid at para 66 where the Court outlines that the Supreme Court of Appeal had accepted that

> '[reasonable measures] [in casu] would translate into the proper screening of incoming [inmates], inclusive of a physical chest examination; separating out those who had, or were suspected of having TB, or who were obviously under nourished and vulnerable to TB; the provision of adequate nutrition to those who were undernourished and otherwise vulnerable to TB; regular and effective screening of the prisoner population, inclusive of examinations by means of X-Rays and/or physical chest examinations by means of a stethoscope, to identify possible TB infection; isolation of infectious inmates and effective implementation of the DOTS system over the prescribed period of time.'

[332] *BAT I* supra note 68 and *BAT II* supra note 68.

of expression under section 16(1) of the Constitution. When considering this case, it is worth noting that the intervention under consideration (namely marketing restrictions) lay wholly outside the healthcare sector.

In considering whether the limitation of this right was justifiable, Phatudi J gave significant weight to the public health purposes of the ban which extended beyond tobacco users to 'passive smokers', stating:

> 'I am of a strong view that protection of "public health interest" is one of the fundamental rights that override the interest of an individual including that of the applicant The right to freedom of expression is not absolute and cannot override the interest of the democratic society. Advertising of a tobacco product is made solely for the interest of a person with a sole purpose of persuading or enticing members of the public to patronise the product. In fact, the main purpose of advertising tobacco product is to promote the use of the harmful product which often becomes fatal even to the consenting adult tobacco consumers. The tobacco is more harmful to passive smokers especially children who find themselves, without choice, in motor vehicle(s) in which a smoker is a passenger and smoking.'[333]

Despite the recognition of this 'public health' objective as a basis to justify the advertising ban, the High Court did not expressly invoke a rights-based approach to justifying the ban. The Supreme Court of Appeal, however, approached the limitations analysis with reliance on both section 24 and section 27. The majority judgment, penned by Mthiyane DP, focused primarily on the public health objectives behind the advertising ban with references to both sections 24 and 27 of the Constitution. The Court explicitly linked the public health objectives of the ban to the right to a healthy environment, stating: 'The public health considerations and the countervailing right to a healthy environment make a strong case for the limitation of the right which the appellant seeks to enforce.'[334]

In determining the constitutionality of the advertising ban, the Court recognised the role that such a ban could play in protecting public health.[335] Though the Court linked the implementation of the ban to South Africa's obligations under the Framework Convention on Tobacco Control, it also invoked constitutional rights. Specifically, the Court found that government had an obligation to implement tobacco control measures in terms of section 27 of the Constitution:

> 'There can be no question that government has an obligation to protect its citizens from the ravages of tobacco use. Smoking is undoubtedly hazardous and has an adverse effect on health care. In terms of s 27(1) of the Constitution everyone has the right to have access to health care services which the State is obliged to provide and to carry the costs of, if necessary.'[336]

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[333] *BAT I* supra note 68 at para 35
[334] *BAT II* supra note 68 at para 28.
[335] Ibid at para 20 which states:

> 'In addition to these objectives, the Act (as amended by the 2007 Amendment Act and the 2008 Amendment Act) seeks to ensure that South Africa complies with its obligations in terms of the [FCTC] which came into force on 27 February 2005. The Act (as amended), also seeks to close loopholes in earlier versions of the Act which allowed for the subverting of provisions of the Act by individuals and tobacco companies. Most importantly, the Act seeks to protect and promote public health in South Africa which is of national concern.'

[336] Ibid at para 26.

It is not clear from this paragraph how the ban impacts the state's obligation to provide citizens with access to healthcare services under section 27(1). This is particularly so given that the ban is not part of the provision of healthcare under the right. However, if contextualised by the Court's earlier statements on the impact that tobacco use has on the healthcare system, this may be interpreted as drawing a link between tobacco use and the impact this use has on the realisation of this right for South African's more broadly. In other words, how the ban indirectly assists in protecting the right under section 27 by reducing the burden on the healthcare system. Referring to a Canadian case, Mthiyane DP noted the substantial impact tobacco has on the public healthcare system:

> 'As to the public health considerations that appeared to have informed the ban on advertising, it is also necessary to have regard to how the problem has been dealt with in other jurisdictions. … The remarks of McLachlin CJ are apposite: '[T]obacco is now irrefutably accepted as highly addictive and as imposing huge personal and social costs. We now know that half of smokers will die of tobacco-related diseases and that the costs to the public health system are enormous. We also know that tobacco is one of the hardest addictions to conquer and that many addicts try to quit time and time again, only to relapse.'[337]

Farlam JA's concurring judgment also linked the ban (and the public health objectives more specifically) to section 24 stating:

> 'I say this because the public health considerations addressed by the Act and set out in the Framework Convention and the right to an environment that is not harmful to the health and wellbeing of all in this country, which is entrenched in s 24 of the Constitution, clearly constitute powerful reasons for upholding the limitation'[338]

The *BAT II* case aligns with the collectivist enforcement of the right to healthcare adopted in *Soobramoney* and *TAC,* but extends this content, when read with section 24, to include the prevention of illness and disease through measures that fall outside the healthcare section. However, the invocation of section 24 raises the question of how transferable this expanded reading may be to risk factors such as alcohol and unhealthy food and beverages which also cause NCDs.

Specifically, section 24(a) provides that 'everyone has the right to an environment that is not harmful to their health or well-being'. The *BAT* case demonstrated that this entitlement can be given a fairly broad reading in respect of health outcomes, supporting the adoption of a measure which could, indirectly, lead to less smoking. Importantly, the protection of this right allows for enforcement against private actors whose products or actions may lead to people's health being harmed. This aligns with, for example, the close connection between health and the environment adopted by the African Commission in *SERAC,* where the right to health was read to specifically include a protection against the activities of private actors that may adversely impact people's health.[339] The reading of section 27(1)(a) with section 24(a) also provides support for Pieterse's earlier assertion that the Constitution contains a composite right to health with different rights protecting different components or antecedents to good health.

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[337] Ibid at para 24, referencing *Canada (Attorney General), v JTI-MacDonald Corp 2007* SCC 30 at para 9
[338] Ibid at para 40.
[339] *SERAC* supra note 270 at para 67.

However, section 24(b) limits the enforcement of this section to measures that would prevent, inter alia, 'pollution and ecological degradation'.[340] The use of combustible tobacco products can be accommodated within this definition due to the pollution that directly results from tobacco use. Yet the link to pollution and ecological degradation is more tenuous in the case of the food and beverage industry, with little ecological degradation emanating from the use of these products by consumers (as opposed to that which arises from their production). As a consequence, while the *BAT II* decision affirms that section 27 can be read to include health interventions seated outside the healthcare section, this affirmation is of limited application to other NCD risk factors.

(iii)The right to healthcare under COVID-19

The outbreak of the SARS-CoV-2 pandemic (COVID-19) from late 2019 saw the government having to navigate difficult new terrain, faced with questions of how best to respond to a novel virus with a limited array of public health interventions – most of which are situated outside the healthcare system. The response to the pandemic also prompted extensive litigation, requiring the judiciary to delineate its role in the midst of a public health crisis and, of relevance to this Chapter, to consider how to balance competing rights with public health objectives.

On 15 March 2020, a national state of disaster was declared under the Disaster Management Act (DMA).[341] This declaration was accompanied by a series of regulations aimed at the prevention and containment of COVID-19, which employed traditional public health interventions utilised to control the spread of infectious diseases. These included regulations requiring increased handwashing and the use of sanitiser, the introduction of social distancing measures, mandatory isolation, quarantine, testing and mask wearing, as well as the criminalisation of non-compliance with certain provisions.[342] These measures have constituted the traditional armamentarium to control communicable diseases for centuries, and sit outside of the healthcare system. As such, they are often termed non-pharmaceutical interventions (NPIs).

The far reaching measures undertaken were perceived as draconian by some, or were seen to unduly place public health above economic interests. This, coupled with a shifting and uncertain evidence base, resulted in extensive litigation, often requiring the courts to consider whether the public health objectives sought by these interventions could justify the limitation of constitutional rights.[343] The countervailing objective sought through these regulations was

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[340] Specifically, section 24(b) of the Constitution provides that everyone has the right:

> 'to have the environment protected, for the benefit of present and future generations, through reasonable legislative and other measures that-
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> prevent pollution and ecological degradation;
> promote conservation; and
> secure ecologically sustainable development and use of natural resources while promoting justifiable economic and social development'

[341] 57 of 2002.

[342] Regulations issued in terms of section 27(2) of the Disaster Management Act, 2002 GN 318 in *GG 43107* of 18 March 2020.

[343] In *Esau and Others v Minister of Co-Operative Governance and Traditional Affairs and Others* 2021 (3) SA 593 (SCA) at para 1, Plasket JA succinctly summarises the issues raised by the pandemic as:

the protection of public health. Under section 27(3) of the DMA, the Minister of Cooperative Governance and Traditional Affairs (COGTA) was permitted to make regulations for specific purposes related to the containment and control of the disaster, namely: assisting and protecting the public; providing relief to the public; protecting property; preventing or combating disruption; or dealing with the destructive and other effects of the disaster.'[344]

The Executive, in defending the regulations under challenge at different points, relied on the objective of protecting public health and the healthcare system, and over time began to invoke the constitutional rights that the regulations sought to protect or promote.[345] In *Esau*, the Minister of COGTA argued that the COVID-19 regulations worked to promote the rights to life, freedom, security of person and access to the healthcare system – not of a particular person but of broader South African society.[346] The Supreme Court of Appeal accepted the argument that these NPIs served to protect societal rights, specifically the right to life:

> 'At its most basic, the purpose of the limitation of the fundamental right to freedom of movement and of trade, occupation and profession was the protection of the health and lives of the entire populace in the face of a pandemic that has cost thousands of lives and has infected hundreds of thousands of people. In a sense, there has been something akin to a trade-off: the rights to freedom of movement, to dignity and to pursue a livelihood were limited to prevent the spread of Covid-19 and that, in turn, protected the right to life of many thousands of people, who would have died had the disease had the opportunity to run unchecked through the country.'[347]

The role of these NPIs, and the balancing act government was engaged in, was described by Plasket JA as a form of protecting and promoting collective rights:

> 'The importance of the purpose of the limitations of fundamental rights is self-evident. The strict lockdown was principally intended to "flatten the curve" – to slow the spread of Covid-19 in order to buy time for the health care system to expand its capacity, for the preparing and equipping of health care facilities with such necessary equipment as PPE and ventilators, and for intensifying testing and prevention programs. The lockdown brought with it the obvious drawback that economic activity, for the most part, ground to a halt. The level 4 regulations

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> 'The Republic of South Africa has been under a state of national disaster, declared in terms of the [DMA], since 15 March 2020. The purpose of the declaration and the subsequently promulgated regulations and directions was and is to prevent and contain the spread of the SARS-CoV-2 or Coronavirus Disease 2019 (Covid-19) and to regulate the State's response to the pandemic that has caused such widespread health and economic devastation in the country. In the course of doing so, it is beyond doubt that many of the regulations and directions issued by the national executive have limited the rights of the populace. This appeal concerns the constitutional validity of certain decisions taken by members of the executive and of regulations made in order to deal with the pandemic.'

[344] Section 27(3) of the DMA read with *Esau* supra note 343 at para 16.

[345] *Esau* supra note 343.

[346] Ibid at para 121 which reads:

> 'The COGTA Minister's starting point in justifying the regulations under attack was that the State was under an obligation to respect, protect, promote and fulfil the fundamental rights of everyone to life, to freedom and security of the person and to access to health care services. These rights were threatened by the pandemic. In order to arrest the spread of Covid-19, it was necessary to compel people to remain at home. The logic is clear:
>
> > "Uninfected persons who stay at home minimize their contact with infected persons and infected surfaces. Infected persons who stay at home reduce the occasions upon which they may infect others or public surfaces."'

[347] Ibid at para 132.

> were aimed at allowing greater economic activity while, at the same time, keeping in place the lockdown, albeit in terms not as restrictive as before.'[348]

The High Court gave similar recognition of the role of NPIs in protecting the right to life, which concerned the constitutionality of the ban on the sale of tobacco products. In *British American Tobacco South Africa (Pty) Ltd and Others v Minister*[349] and in *Fair-Trade Independent Tobacco Association*,[350] the Minister again invoked the right to life and the strain on the public health care system to justify the prohibition:

> 'The Minister states that the overarching reasons for the decision to continue prohibiting the sale of tobacco products in Alert Level, 3 are to protect human life and to reduce potential strain on the healthcare system, particularly given the predicted steep rise in the rate of infections by the novel coronavirus following the lifting of the Level 4 restrictions on work and the movement of people to re-start the economy. According to the Minister, the Constitution imposes positive duties on the State to protect, promote and fulfil the rights in the Bill of Rights - including the right to life and the right to access to healthcare services. Thus, the State has a duty to take steps to prevent the spread of disease and to reduce the burden on the healthcare system, so as to ensure that those who need these services can have access to them. This duty is particularly acute in a pandemic.'[351]

This reading of section 27, which could encompass a measure such as a tobacco sales ban to protect the capacity of the healthcare system, was successful in *FITA,* with the Court expressly finding that the ban was in line with the state's duty under section 27:

> 'We hold the view that a vigorous attempt to contain the spread of the virus at all costs had to be made especially bearing in mind the high COVID-19 mortality rates and the fact that, as a developing country with limited resources as well as an already overwhelmed healthcare system, South Africa is ill-equipped to survive the full brunt of the pandemic at its peak if no concerted efforts are made to contain the virus. In line with its constitutionally mandated duties to preserve life and provide adequate health care, the State was under a duty to adopt measures to ensure that the already fragile healthcare system was not overwhelmed even further.'[352]

In *One South Africa,*[353] the Court went even further in expanding the content of section 27 beyond COVID-19 measures. The broad reading adopted by the Court saw the realisation of the right to health not purely in terms of ensuring access for patients but as part of broader social and development obligations. The Court went so far as to read the growth of the economy as a means for the state to fulfil its obligations under section 27, stating:

> 'In this case, the constitutional issue implicates a range of fundamental rights, which pull in different directions. The measures the state adopts to deal with the threat posed to the right to life must in turn safeguard and protect other constitutional rights which are also affected by

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[348] Ibid at para 130.

[349] *British American Tobacco South Africa (Pty) Ltd and Others v Minister of Co-operative Governance and Traditional Affairs and Others* [2020] ZAWCHC 180 (*BAT III*).

[350] *Fair-Trade Independent Tobacco Association v President of the Republic of South Africa and Another* 2021 (1) BCLR 68 (GP).

[351] *BAT III* supra note 349 at para 89.

[352] *FITA* supra note 350 at para 42.

[353] *One South Africa Movement and Another v President of the Republic of South Africa and Others* 2020 (5) SA 576 (GP).

> the Covid-19 crisis. Section 7(2) expressly requires this of the state. These include, for example, the right to reasonable access to health care services for all the population, and not only for Covid-19 patients; the right to freedom of movement; the right to dignity which attaches to the ability to earn a living and feed one's family; the right to free choice of one's trade, profession and occupation; and the right to property. Moreover, the measures that the state adopts must also not hinder its ability to meet its constitutional obligations progressively to provide access to housing, social-welfare, health care and education. The health of the economy and fiscus are central to its ability to do so.'[354]

This interpretation was likely heavily influenced by the context of the case, as the applicants were arguing for a continuation of a 'hard lockdown' to prevent the spread of COVID-19 and save lives, while the government was defending its efforts to re-open the economy despite likely compromising public health to some degree. Nevertheless, the case still aligns and reflects the more generous interpretation afforded to section 27(1)(a).

The invocation of further rights to complement section 27(1)(a), coupled with the more generous reading of the right to healthcare, also provides further support for the notion that these constitutional rights may be read together to form a composite right to health, with different entitlements covering different antecedents of health.

VI. DISCUSSION

This Chapter has discussed the ambit, content and functioning of the section 27(1)(a) to understand the extent to which South Africa's Constitution contains a right to health. Although the jurisprudence on the right to healthcare is still developing, specifically within the context of COVID-19, the existing jurisprudence illustrates that the courts have adopted a generous interpretation to what actions constitute fulfilment and protection of the right to healthcare. These interpretations have permitted reliance on section 27 in justifying measures that limit other rights, even where there is no clear beneficiary under section 27 and even where the measure sits outside the healthcare sector. Even within the clearly healthcare-linked focus of *Soobramoney*, the concurring judgments were beginning to assert a broader reading of section 27(1)(a) beyond one solely linked to bio-medical and pharmaceutical interventions.

Of most relevance is the degree to which preventative interventions are encapsulated within section 27. What emerges from the *TAC* case onwards is an intention to imbue preventative interventions with the support of constitutional rights. This aligns closely with the CESCR statements on the right to health and disease prevention, in which it is recognised that achieving good health and preventing disease require the 'the promotion of social determinants of good health, such as environmental safety, education, economic development and gender equity' under the article 12.2(c) obligation to prevent, treat and control diseases.[355] Consequently, NCD prevention measures related to unhealthy food and beverages can find support within the right to healthcare insofar as they seek to lessen the burden on South Africa's resource constrained healthcare system.

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[354] Ibid at para 90.
[355] General Comment 14 at para 16.

While there is support for this disease prevention under section 27(1)(a) and the right to healthcare, it is worth noting that courts have frequently also invoked additional rights, such as the right to life or the right to a healthy environment, to strengthen the constitutional basis for public health interventions that infringe other rights. This is particularly true of the cases concerning limits on the sale and use of tobacco products, and thus would likely extend to other NCD prevention measures. The tension between the public health objectives and other civil and political rights lends a level of complexity to the analysis of whether these public health aims can justifiably override competing constitutional rights. Of this, the Court in *One South Africa*, stated:

> 'Even within the context of the right to life, there are interests that pull in a different direction. It has been held that the right to life means something more than biological life. It is intertwined with the dignity of human beings. Both are central to a society in which each member of the community is recognised and treasured. The right to life includes the right to share in the experience of humanity. Stringent lockdown measures adopted to deal with that threat of Covid-19 threaten this aspect of the right to life. The measures government adopts to deal with the epidemic must also be sensitive to the need to safeguard, as far as possible, the right to life in its fullest sense. Thus, the right to life question is not simply about the obligation to guard against preventable deaths.'[356]

Solely linking these efforts to the protection of a diffuse societal right to healthcare may be insufficient where interventions are ongoing or involve longstanding incursions on individual rights. This constitutional or rights-based approach to NCD prevention measures may be buttressed or strengthened through the invocation of other rights. As was noted in the *TAC* decision, 'the rights in the Constitution are mutually supportive and have a significant impact on the dignity of people and their quality of life'. In reading rights together, there is support for the contention that these entitlements yield a composite constitutional right to health similar in content to article 12 of the ISCECR. However, it is necessary to carefully consider how the content of these other rights may be used to support the goals of disease prevention, and to reflect on the extent to which there are health-related entitlements under these other constitutional rights. In this regard, the next Chapter will explore the manner in which the right to food may be read with the right to healthcare to support stronger action on NCDs.

VII. CONCLUSION

Non-pharmaceutical interventions, including those seated outside the healthcare system, can operate to protect or fulfil the right to healthcare contained in section 27(1)(a), even where the measures do not have clear beneficiaries and where they infringe other rights. This lends credence to the assertion that South Africa's Constitution contains a composite right to health that aligns substantively to the components of the right to health contained in ICESCR. This is further supported by the fact that the justification for infringements resulting from the adoption of NPIs may be strengthened by invoking additional rights and reading these rights with the right to healthcare in a mutually supportive manner. The next Chapter will consider the utility of the right to food as a supportive right to the right to health in the context of NCD prevention efforts.

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[356] *One South Africa* supra note 353 at para 91.

CHAPTER 4
THE CONTENT OF THE SOUTH AFRICAN RIGHT TO ACCESS TO SUFFICIENT FOOD IN RELATION TO NUTRITIONAL SUFFICIENCY AND OVERNUTRITION

I. INTRODUCTION

The right to food remains largely defined in terms of addressing a lack of access to food, with discourse dominated by the undernutrition that follows from this lack of access.[357] As a consequence, food security has been viewed as a key component of the right to food. Initially, food insecurity was defined through the availability of food, and problems of food security, it was believed, could be solved through increasing food production.[358] Similarly, the core content and obligations arising from the right to food have been framed almost exclusively in relation to undernutrition and hunger. The Committee on Economic, Social and Cultural Rights (CESCR), for instance, framed a state's duty to ensure its citizens are free from hunger as a priority obligation in General Comment 12.[359] Over time, the concept of food security – and the role of the right to food in addressing food insecurity – evolved to focus primarily on access to food. In particular, economic access emerged as a central feature of addressing hunger and food insecurity.[360] Amartya Sen stated this concisely: 'starvation is the characteristic of some people not having enough food to eat. It is not the characteristic of there being not enough food to eat.'[361]

Due to the increasing prevalence of obesity, and the associated overnutrition and diet-related non-communicable diseases, South Africa is now moving into a phase in which there may be enough food accessible to the poorest in our society, but not enough of the right kinds of food, ultimately leading to the increased prevalence of illnesses.[362] This is compounded by the continuing burden of undernutrition and high levels of food insecurity within South Africa, giving rise to a double burden of malnutrition.[363] Within the public health space, some have

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[357] Danie Brand 'Between Availability and Entitlement: The Constitution, Grootboom and the Right to Food' (2003) 7 *Law, Democracy & Development* 1; Fons Coomans and Kofi Yakpo 'Framework Law on the Right to Food - An International and South African Perspective' (2004) 4 *African Human Rights Law Journal* 17; Sibonile Khoza 'Realising the Right to Food in South Africa: Not by Policy Alone–Need for Framework Legislation' (2004) 20 *South African Journal on Human Rights* 664; Bright Nkrumah 'Opening Pandora's Box: A Legal Analysis of the Right to Food in South Africa' (2019) 52 *De Jure Law Journal* 47.

[358] Francesco Burchi and Pasquale De Muro 'A Human Development and Capability Approach to Food Security - Conceptual Framework and Informational Basis' (2012), *UNDP Working Paper* at 2.

[359] Committee on Economic, Social and Cultural Rights 'General Comment No. 12 Substantive issues arising in the implementation of the International Covenant on Economic, Social and Cultural Rights: The right to adequate food (art 11 of the Covenant)' E/C.12/1999/5 (12 May 1999) available at https://www.refworld.org/pdfid/4538838c11.pdf, accessed 23 July 2021 at para 17 (General Comment 12). See also the discussion in Danie Brand 'The Right to Food' in Christof H. Heyns and Danie Brand (eds.) *Socio-Economic Rights in South Africa* (2005) at 161.

[360] Brand op cit note 324 at 3.

[361] Amartya Sen, *Poverty and Famines: An Essay on Entitlement and Deprivation* (1981) at 1.

[362] Yuri Ramkissoon 'The Right to Access Nutritious Food in South Africa: Feature' (2018) 19 *Economic and Social Rights in South Africa* at 8.

[363] Karen J Hofman, Agnes Erzse, Petronell Kruger et al 'Double Burden and Double Duty: Government Action Required to Improve Child Nutrition' *South African Child Gauge 2020* 135 at 137.

suggested utilising section 27 of the Constitution – and specifically the right to sufficient food – to support and compel policies to curb nutrition transition and promote the accessibility of healthier foods.[364] This concept of overnutrition and its relationship with the right to food poses a challenge to the current conceptualisation of the right to food, within which infringements of the right and a lack of realisation of the right are framed as a consequence of lack of access to food. In this context, there is a need to understand the relationship between the constitutional right to food, overnutrition and unhealthy food environments, and to consider the extent to which the nutritional composition of food informs obligations under the right to food.

This Chapter attempts to define the content of the section 27(1)(b) right to sufficient food in relation to issues of nutrition and access to healthy food with a specific view to addressing overnutrition. It begins by providing a background on how the food environment has changed and the impact of this change on health. The Chapter then outlines how issues of nutrition and healthfulness of food are included in the definition of the right to food under international and regional instruments. It then discusses how the right to food has been defined under the South African Constitution and in case law. The differences between the right to 'adequate food' under international law and the right to 'sufficient food' under the Constitution are explored, and an approach which reconciles this distinction is suggested. I then discuss how considerations of the nutritional adequacy of food may be located within the ambit of the South African right to sufficient food, and how issues of overnutrition may be framed to give rise to obligations under section 27(1)(b).

II. CHANGING FOOD ENVIRONMENTS AS A DRIVER OF NCDS

Though non-communicable diseases have traditionally been viewed as arising from individual behaviours, it is becoming more apparent that societal structures and corporate actors play a major role in the growing NCD epidemic – both in South Africa[365] and globally.[366] Globalisation has resulted in changing lifestyles and diets,[367] and has seen the increased proliferation and normalisation of unhealthy commodities.[368] This is a result of transnational corporations and manufacturers moving into new markets, particularly low- and middle-income countries (LMICs), where they pursue aggressive measures to increase the availability, acceptability and accessibility of their products.[369] This has resulted in movement away from traditional diets to a 'Western diet', increasing consumption of ultra-processed foods high in sugar, salt and fats – a phenomenon that has been termed the 'nutrition transition'. These nutrition transitions are not accidental. South Africa has undergone a nutrition transition which has seen traditional foods and diets replaced by cheap, energy-dense, nutrient-poor foods.[370] This is driven, at least in part, by a changing food environment which makes highly processed and unhealthy foods increasingly accessible, available and palatable to consumers.[371] In

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[364] Spires et al op cit note at 39.
[365] Delobelle et al op cit note 25; Igumbor et al op cit note 29.
[366] Gostin op cit note 12; Magnusson and Patterson op cit note 34; Moodie et al op cit note 26; Stuckler et al op cit note 26.
[367] Popkin and Gordon-Larsen op cit note 27.
[368] Beaglehole and Yach op cit note 4; Moodie et al op cit note 25; Stuckler et al op cit note 25.
[369] Igumbor et al op cit note 24; Delobelle et al op cit note 24.
[370] Spires et al op cit note 24 at 40.
[371] Ibid.

contrast, healthier foods are typically more expensive and of limited availability in low income areas.[372] This has reduced and compromised the dietary diversity of poorer populations.

Unlike many of the other issues concerning the right to food, the point of departure in considering the prevention of food-related NCDs is that the infringement or non-realisation of the right emanates not in the availability or accessibility of food, but rather in the lack of accessible *healthy* foods in contexts where there is an abundance of cheap, appetizing foods that, when consumed, are ultimately harmful to health. This Chapter seeks to investigate the degree to which the right to sufficient food contained in the Constitution can encompass a right to healthy and nutritious food, and how it can be used in support of improving diet and preventing NCDs.

III. CONTENT OF THE RIGHT TO FOOD UNDER INTERNATIONAL LAW

(a) Recognition of the right to food and nutrition under international human rights instruments

The right to food was first recognised in the UDHR as part of 'the right to a standard of living adequate for the health and well-being of himself and of his family, including food'.[373] Under ICESCR, the right to food was developed as part of a composite set of entitlements, including a right to housing and clothing, which together support the right to an adequate standard of living.[374] Article 11.2 outlines further direct obligations related to the right to food, stipulating that states have an obligation to take steps to ensure that everyone is free from hunger – by, for instance, improving the distribution and production of food, and ensuring equitable distribution of food globally.[375]

In 2005, the FAO adopted a set of 19 Voluntary Guidelines which specified how member states should ensure that their right to food obligations were met.[376] In addition to these moves at the international level, the past decade has 'also witnessed a surge in interest in

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[372] Noluthando Ndlovu, Candy Day, Jens Aagaard-Hansen et al 'Assessment of Food Environments in Obesity Reduction: A Tool for Public Health Action' (2018) *South African Health Review* at 115.

[373] Article 25(1) of the UDHR.

[374] Article 11.1 of ICESCR reads:

> 'The States Parties to the present Covenant recognize the right of everyone to an adequate standard of living for himself and his family, including adequate food, clothing and housing, and to the continuous improvement of living conditions. The States Parties will take appropriate steps to ensure the realization of this right, recognizing to this effect the essential importance of international co-operation based on free consent.'

[375] Article 11.2 of ICESCR reads as follows:

> 'The States Parties to the present Covenant, recognizing the fundamental right of everyone to be free from hunger, shall take, individually and through international co-operation, the measures, including specific programmes, which are needed:
>
> To improve methods of production, conservation and distribution of food by making full use of technical and scientific knowledge, by disseminating knowledge of the principles of nutrition and by developing or reforming agrarian systems in such a way as to achieve the most efficient development and utilization of natural resources;
>
> Taking into account the problems of both food-importing and food-exporting countries, to ensure an equitable distribution of world food supplies in relation to need.'

[376] Food and Agriculture Organisation, Voluntary Guidelines 2005 available at http://www.fao.org/docrep/009/y7937e/y7937e00.htm, accessed 31 March 2020.

the domestic enforceability of the human right to food' as domestic laws are increasingly beginning to incorporate the right to food.[377]

The right to food also has some recognition under CEDAW in certain limited or indirect ways. Under article 12, states are required to ensure women have access to adequate nutrition, though this is limited to phases of pregnancy and lactation. Article 14 more broadly recognises the right of rural women to some of the antecedents to the realisation of the right to food, such as access to land, water and social security.[378] Further, under CRC, there is recognition of nutrition as a component of the realisation of the child's right to the enjoyment of the highest attainable standard of health. Under article 24.2, states are required to combat malnutrition, inter alia, through the provision of adequate nutritious foods and by ensuring that parents and children are educated on child health, nutrition and breastfeeding.[379] Article 27 also recognises a child's right to an adequate standard of living which enables 'physical, mental, spiritual, moral and social development'. Under this article, primary responsibility to provide the living conditions needed to achieve this development lies with the parents, but states have an obligation to assist parents, in particular by providing assistance and support for nutrition.[380]

One of the most comprehensive discussions on the right to food is found in the General Comment 12 on the right to adequate food, defining the right as comprising a complex set of entitlements related to access in different forms: 'The right to adequate food is realized when every man, woman and child, alone or in community with others, has physical and economic

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[377] Nandini Ramanujam, Nicholas Caivano, and Semahagn Abebe 'From Justiciability to Justice: Realizing the Human Right to Food' (2015) 11:1 *McGill International Journal of Sustainable Development Law and Policy*.

[378] Article 14.2 of CEDAW reads in part:

> 'States Parties shall take all appropriate measures to eliminate discrimination against women in rural areas in order to ensure, on a basis of equality of men and women, that they participate in and benefit from rural development and, in particular, shall ensure to such women the right:
> …
> (c) To benefit directly from social security programmes;
> …
> (g) To have access to agricultural credit and loans, marketing facilities, appropriate technology and equal treatment in land and agrarian reform as well as in land resettlement schemes;
> (h) To enjoy adequate living conditions, particularly in relation to housing, sanitation, electricity and water supply, transport and communications.'

[379] Article 24.2 of the CRC states:

> 'States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures:
> …
> (c) To combat disease and malnutrition, including within the framework of primary health care, through, inter alia, the application of readily available technology and through the provision of adequate nutritious foods and clean drinking-water, taking into consideration the dangers and risks of environmental pollution;
> …
> (e) To ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of accidents'

[380] Article 27.3 reads 'States Parties, in accordance with national conditions and within their means, shall take appropriate measures to assist parents and others responsible for the child to implement this right and shall in case of need provide material assistance and support programmes, particularly with regard to nutrition, clothing and housing.'

access at all times to adequate food or means for its procurement'.[381] In outlining the ambit of the right to food, the General Comment includes the right to be free from both hunger and malnutrition, with greater immediacy in the state's obligation to address hunger.[382] Within the text of the Convention, the dimension of proper nutrition is only captured in the obligation to disseminate knowledge. Implicitly, however, there are clear indications that the nutritional sufficiency of food is a component of the right. General Comment 12 explicitly highlights the relationship between the right to adequate food and dignity as 'indivisible', and affirms that the realisation of the right to adequate food is indispensable to the realisation of other fundamental rights.[383] Within General Comment 12, much discussion is devoted to the undernutrition and hunger aspects of malnutrition. The Comment also states that the adequacy of food should not be determined narrowly as merely a 'minimum package of calories, proteins and other specific nutrients'.[384] There is, however, no fixed definition of adequacy offered but rather a number of factors that might inform what food is considered adequate, including social, economic, cultural and ecological conditions.[385]

Against this backdrop, the Comment outlines the core content of the right to adequate food as 'the availability of food in a quantity and quality sufficient to satisfy the dietary needs of individuals, free from adverse substances and acceptable within a given culture'. It moreover affirms that such food should be accessible in a sustainable manner which does not conflict with the enjoyment of other HR.[386] This outlines the critical components of the right to food, which include availability, accessibility and acceptability, as well as specific requirements for food safety and nutritional content. The obligations related to availability, accessibility and adequacy of food are well developed, as they apply not only to the right to food but also to other socio-economic rights.

Availability focuses on the sufficiency of food supply, and has historically been strongly linked to food production at both subsistence (that is, people producing their own food) and commercial levels.[387] Accessibility is understood to include both physical and economic accessibility. During his tenure as UN Special Rapporteur on the right to food, De Schutter expounded upon accessibility and its relationship to adequacy of diet, stating: 'Economic accessibility means that food must be affordable. Individuals should be able to afford food for an adequate diet without compromising on any other basic needs, such as those related to housing, education of healthcare.' [388] This reiterates the interrelationship food often has with other rights. De Schutter also argued that where food that is financially accessible is not nutritionally adequate, that access should be understood as falling short of meeting the obligations of access to adequate food.

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[381] General Comment 12 at para 6.
[382] Ibid.
[383] Ibid at para 4.
[384] Ibid at para 6.
[385] Ibid at para 7.
[386] Ibid at para 8.
[387] Ibid at para 12.
[388] Olivier De Schutter 'From Charity to Entitlement: Implementing the Right to Food in Southern and Eastern Africa' *United Nations Special Rapporteur on the Right to Food* June 2012 available at https://www.ohchr.org/Documents/Issues/Food/SRRTF%20BN%2005_SouthernEasternAfrica_en.pdf at 5.

The General Comment 12 elaborates on 'dietary needs' and, interestingly, highlights the need to maintain and strengthen dietary diversity to ensure that changes in the availability and accessibility of food do not negatively impact the composition and intake of people's diets.[389] Specifically, the statement draws links between physical and mental growth and development, and dietary intake, stating:

> 'Dietary needs implies that the diet as a whole contains a mix of nutrients for physical and mental growth, development and maintenance, and physical activity that are in compliance with human physiological needs at all stages throughout the life cycle and according to gender and occupation. Measures may therefore need to be taken to maintain, adapt or strengthen dietary diversity and appropriate consumption and feeding patterns, including breastfeeding, while ensuring that changes in availability and access to food supply as a minimum do not negatively affect dietary composition and intake.'[390]

This statement draws linkages between diet and aspects of one's health, and in this manner appears, inter alia, to recognise the potential adverse consequences of nutrition transition as experienced in many LMICs, including South Africa.

The components specific to food discussed in General Comment 12 include the following: that food should be free from adverse substances (i.e. safe to consume)[391]; that it should be culturally or otherwise acceptable[392]; and that it should meet dietary needs.[393] De Schutter drew a particular link between these various components of the right to food, positioning them within the umbrella of 'adequate food'.[394] He went further to explicitly link nutritional adequacy of food and non-communicable diseases:

> 'Adequacy means that the food must satisfy dietary needs, taking into account the individual's age, living conditions, health, occupation, sex, etc. For example, if children's food does not contain the nutrients necessary for their physical and mental development, it is not adequate. Food should also be safe for human consumption and free from adverse substances, such as contaminants from industrial or agricultural processes, including residues from pesticides, hormones or veterinary drugs. Adequate food should also be culturally acceptable. For example, aid containing food that is a religious or cultural taboo for the recipients or inconsistent with their eating habits would not be culturally acceptable. Finally, adequate diets must be sufficiently diverse, and covering all food groups in a balanced manner, in order to be healthy and not to expose the individual to diet-related non-communicable diseases.'[395]

In this manner, De Schutter explicitly stated that where the type of food being consumed would lead to NCDs, this food falls short of the requirements of the right to food.

More recently, the UN Special Rapporteur on the right to health, Dainius Pūras, specifically recognised access to safe and nutritious food as a component of the right to health

[389] General Comment 12 at para 9.
[390] Ibid.
[391] Ibid at para 10.
[392] Ibid at para 11.
[393] Ibid at para 9.
[394] De Schutter op cit note 388 at 5.
[395] Ibid.

within the context of NCD prevention efforts, highlighting the interrelationship between nutrition and the right to health:

> 'The right to health is an inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health, such as an adequate supply of safe food and nutrition. States' obligations therefore include ensuring equal access for all to nutritiously safe food as an underlying determinant of health.'[396]

There is consequently an increased recognition of the link between the right to food and the right to health within the context of the growing NCD epidemic. Various facets of the right to food, specifically adequacy and accessibility, have been developed to take cognisance of this link.

(b) The right to food under regional African instruments

Though there is no explicit and formal recognition of the right to health under the African Charter, the right to food has been recognised as being implicitly protected within the ambit of other provisions of the Charter. In *Social and Economic Rights Action Center and another v Nigeria* (*SERAC*),[397] the Commission recognised a right to food as implicitly contained in both article 4 (the right to life) and article 16 (the right to health) of the African Charter.[398] The Commission recognised that the right to food was not explicitly recognised in the Charter but that the right to food was integral to the enjoyment of other rights, stating:

> 'While the right to food is not specifically enumerated in the African Charter, it is implicit in such provisions as the right to life (art.4), the right to health (art. 16) and the right to economic, social and cultural development (art. 22) . . .. It is undeniable that food is central to the enjoyment of such other rights as health, education, work and political participation.'[399]

This resonates with the judicial recognition of the right to food in India, where the right to life was read more expansively to encompass the right to food as an underlying determinant of health and, specifically, as necessary to lead a dignified life.[400]

Following the *SERAC* decision, the African Commission affirmed that the right to food was inherent in the African Charter's protection of other rights and elaborated on the nature of the right.[401] The Commission noted that the right to adequate food was indivisibly linked to the "inherent dignity" of a person and significantly, was indispensable for the fulfilment of other

[396] Daniel Pūras 'Statement by the UN Special Rapporteur on the right to health on the adoption of front-of-package warning labelling to tackle NCDs' available at https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=26130&LangID=E, accessed 27 October 2021.
[397] *SERAC* supra note 270.
[398] Ibid at page 9.
[399] Ibid at page 10
[400] *People's Union for Civil Liberties v Union of India & Others Civil Original Jurisdiction, Writ Petition (Civil) No.196 of 2001 (Supreme Court of India)*. A fuller discussion of this litigation in relation to the right to food and nutrition is contained in Ebenezar Durojaye and Enoch MacDonnell Chilemba 'Accountability and the right to food: A comparative study of India and South Africa' (2018) *Food Security SA Working Paper Series* 003, available at https://foodsecurity.ac.za/wp-content/uploads/2018/06/CoE-FS-WP3-Accountability-and-the-right-to-food.pdf, accessed 26 March 2021.
[401] Nairobi Principles supra note 273 at para 83.

rights including the right to health.[402] The Commission also stated that the right to adequate food consisted of more than a basic package of "calories, proteins and specific nutrients".[403] The Nairobi Principles also specifically incorporate concepts of nutrition security and nutritional adequacy within their definition of food security, stating that "Food security exists when all people, at all times, have physical, social and economic access to sufficient, safe and nutritious food that meets their dietary needs and food preferences for an active and healthy life."[404]

The Maputo Protocol has more limited but more explicit protections related to the right to food. Article XIV.2 outlines a right to health for women and, in respect of nutrition, requires states to take steps to establish and strengthen nutritional services for women during pregnancy and breast-feeding (thus mirroring the protections under CEDAW).[405] Article XV recognises a right to food security which reads:

> 'States Parties shall ensure that women have the right to nutritious and adequate food. In this regard, they shall take appropriate measures to: a) Provide women with access to clean drinking water, sources of domestic fuel, land, and the means of producing nutritious food; b) Establish adequate systems of supply and storage to ensure food security.'[406]

The scope of the right is expansive and explicitly includes a right to nutritious food, requiring that states provide women with many of the antecedents needed for the realisation of that right such as land, water and other means of producing food. Even in this context, the article underscores that the protection applies to nutritious food.

The African Children's Charter also contains specific recognition of obligations related to food under the right to health. Under article 14, states are required to ensure access to adequate nutrition and take steps to address disease and malnutrition.[407] As in the CRC, there are also obligations on states to support parents and provide, inter alia, support for nutrition, health, education, clothing and housing.[408]

Despite the lack of formal and explicit recognition of the right to food in the African Charter, the African Commission has passed resolutions urging states to fulfil obligations under the right to food based on other HR instruments and socio-economic rights. In 2017, the

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[402] Nairobi Principles supra note 273 at para 84.
[403] Nairobi Principles supra note 273 at para 85.
[404] Ibid at para k.
[405] Article XIV.2 of the Maputo Protocol.
[406] Article XV of the Maputo Protocol.
[407] The relevant provisions of article 14.2 read:

> 'State Parties to the present Charter shall undertake to pursue the full implementation of this right and in particular shall take measures:
> …
> (c) to ensure the provision of adequate nutrition and safe drinking water;
> (d) to combat disease and malnutrition within the framework of primary health care through the application of appropriate technology;
> (h) to ensure that all sectors of the society, in particular, parents, children, community leaders and community workers are informed and supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding...'

[408] Article 20.2 of the CRC.

Commission passed a resolution on the right to food and food insecurity.[409] This resolution reflected the essential components of the right to food as an obligation to address hunger, and urged states to 'adopt legislative, administrative and other necessary measures to guarantee the right of everyone to be free from hunger and to mitigate and alleviate hunger'.[410]

In 2019, the Commission passed a further resolution on the right to food and nutrition specifically in Africa (Resolution 431), elaborating on states' duties under existing HR instruments in response to the *SERAC* decision and other developments related to the food system in Africa.[411] The preamble of Resolution 431 notes an explicit concern regarding malnutrition and, specifically, the growing epidemic of NCDs and its impact on people's health.[412] Under the Resolution, the Commission called for states to take a number of steps pertaining to nutrition and health, including steps to ensure enjoyment of the right to food and nutrition – including ensuring access to adequate food to allow for the enjoyment of the right to health. [413] With regard to NCDs, the Commission indicated that states should regulate the importation and marketing of processed foods.[414]

This development of the right to food mirrors that which has unfolded within the UN HR system, but provides more concrete guidance on how to address the growing burden of NCDs within the African region. Specifically, the issue of NCDs is situated at the intersection of the right to health and the right to food within these HR instruments, and the two rights impose distinct obligations on action. While the right to health provides a strong rationale for activities within the healthcare section, the right to food, when seen in the context of how diet contributes to poor health and NCDs, provides the impetus and obligation to prevent NCDs by ensuring that the adequacy and quality of food available is not harmful to health. The issue is whether a similar approach can be adopted in the South African system.

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[409] Resolution 374, Resolution on the Right to Food and Food Insecurity in Africa - ACHPR/Res.374(LX)2017, Niamey, Republic of Niger, on 22 May 2017, available at https://www.achpr.org/sessions/resolutions?id=416, accessed 26 March 2021.

[410] Ibid. at 3.

[411] The African Commission on Human and Peoples' Rights, Resolution on the Right to Food and Nutrition in Africa - ACHPR/Res.431(LXV)2019, adopted 10 November 2019 at the 65th Ordinary Session held from 21 October to 10 November 2019, Banjul, The Gambia, available at https://www.achpr.org/sessions/resolutions?id=462, accessed 26 March 2021.

[412] Resolution 431, in which the preamble states '…concerned that malnutrition which includes conditions such as under-nutrition, micronutrient deficiencies or excess, overweight, obesity and other diet-related non-communicable diseases seriously affects the health and well-being of individuals'

[413] Resolution 431. Relevant excerpts of the resolution include:

> 'The Commission calls on States Parties to:
>
> ….
>
> 1. Take appropriate policy, institutional and legislative measures to ensure the full enjoyment of the right to food which includes constantly accessible and quality food that meets the requirement of nutrition and cultural acceptability;
>
> ….
>
> 5. Ensure that prisoners have access to adequate food for them to fully enjoy their fundamental rights to physical and mental health'

[414] Resolution 431 at para 7 which reads 'The Commission calls on States Parties to…Strictly regulate the importation of foreign food items as well as the promotion and marketing of industrialised and highly processed foods.'

IV. CONTENT OF THE RIGHT TO FOOD IN THE SOUTH AFRICAN CONSTITUTION

As was discussed in the previous Chapter, the right to healthcare contained in section 27(1)(a) can support action to prevent disease, particularly when supported by other rights. The purpose of this discussion is to consider the extent to which the right to food under the South African Constitution can serve as this supporting right.

The Bill of Rights contains a right to food (or nutrition) in three separate sections. Each uses different phrasing and arguably has distinct content. Section 27 contains the general right of access to 'sufficient food' to everyone which is subject to progressive realisation.[415] Both the children's right to basic nutrition[416] and the detainees right to 'adequate nutrition'[417] are unqualified (and both were included in the Interim Constitution).[418] Despite the fact that the right to food, like the other socio-economic rights contained in the Bill of Rights, is justiciable,[419] there is limited case law delineating the content of the right. There are number of cases where litigants have argued that the right to sufficient food has been infringed, yet these arguments have carried little weight when these cases were ultimately decided.[420]

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[415] Section 27 of the Constitution.

[416] Section 28 of the Constitution.

[417] Section 35 of the Constitution.

[418] Interim Constitution of the Republic of South Africa Act 200 of 1993 (the Interim Constitution)

[419] *In re: Certification of the Constitution of the Republic of South Africa, 1996* 1996 (10) BCLR 1253 (CC) (Certification Judgment) at para 78 reads:

> 'Nevertheless, we are of the view that these rights are, at least to some extent, justiciable. As we have stated in the previous paragraph, many of the civil and political rights entrenched in the NT will give rise to similar budgetary implications without compromising their justiciability. The fact that socio-economic rights will almost inevitably give rise to such implications does not seem to us to be a bar to their justiciability. At the very minimum, socio-economic rights can be negatively protected from improper invasion. In the light of these considerations, it is our view that the inclusion of socio-economic rights in the NT does not result in a breach of the CPs.'

[420] In *Flanagan v Minister of Safety and Security* [2018] JOL 40021 (SCA) concerned the detainee's right to adequate nutrition. Here the plaintiff had brought a delictual suit against the State for violations of rights which had occurred during the time he was detained in prison. Among the violations listed was the allegation that he had not received any food during the period of his detention. The claim was successful, however, the decision did not consider whether this constituted a violation of his rights to food in reaching a decision; In *Coastal Links Langebaan and others v Minister of Agriculture, Forestry and Fisheries and others* [2016] JOL 36799 (WCC), a number a fisherman's permits had been restricted. The holders unsuccessfully argued that this decision would impact on food production and thus the food security of the country. In *Zondi v Member of the Executive Council for Traditional and Local Government Affairs and Others* 2004 (5) BCLR 547 (N), the applicant successfully argued that the Natal Pound Ordinance 32 of 1947 which allowed her livestock to be impounded violated, inter alia, her right to sufficient food. The High Court declared the ordinance unconstitutional and invalid. However, when confirmed in the Constitutional Court in *Zondi v MEC for Traditional and Local Government Affairs and Others* [2005] ZACC 18 (CC); 2006 (3) BCLR 423 (CC), the arguments related to the right to food were not taken into consideration. In *Trustees for the time being of the Children's Resource Centre Trust and others v Pioneer Food (Pty) Ltd and others (Legal Resources Centre as amicus curiae)* 2013 (3) BCLR 279 (SCA), the applicants sought to bring a class action against companies involved in price-fixing the cost of bread. The applicants framed their case in terms of the right to sufficient food as they believed they would only be able to bring a class action for a violation of a constitutional right. The applicants argued that the price-fixing activities violated the negative obligation contained in section 27(1)(b). The Supreme Court of Appeal at paragraph 19 held that it was not necessary to frame the class action in terms of a constitutional right.

(a) The right to food under section 27(1)(b)

The right to food is most often discussed in the context of addressing issues of food insecurity and hunger. At a minimum, the constitutional right to food includes an entitlement to be free from hunger.[421] However, in *Wary Holdings* the Constitutional Court considered the content of the right to food (as articulated in section 27(1)(b)) under international law, in the context of agricultural land – and gave it content beyond the immediacy of addressing hunger.[422] The majority judgment, per Kroon AJ, stated:

> 'As the Minister pointed out, international law recognises that the content of the right to food has the twin elements of availability and accessibility. The first element refers to a sufficient supply of food and requires the existence of a national supply of food to meet the nutritional needs of the population generally. It also requires the existence of opportunities for individuals to produce food for their own use. The second element requires that people be able to acquire the food that is available or to make use of opportunities to produce food for their own use. In respect of both elements there is a measure of overlap with the state's obligation under section 25(5) of the Constitution to facilitate equitable access to "agricultural land", and with the State's obligation under section 24 of the Constitution to conserve the environment.'[423] (Footnotes omitted.)

The elements discussed in *Wary Holdings* give content to several dimensions of the right to food, and specifically factors that inform food security such as the means to produce food, an ability to acquire food and the need for sufficient food to be available. To this extent, the elements of acceptability and accessibility as defined under international law form part of the content of the section 27(1)(b) right to access sufficient food.

The content given to the right to food in this case was drawn from a chapter in Brand.[424] Here, Brand relies explicitly upon the right to food contained in both the ICESCR and General Comment 12, discussed in detail above. It is worth briefly outlining the content of the right to food advanced by Brand to inform how the findings in *Wary Holdings* might be understood. The content of the right emphasised is through the lens of food security at both a national and household level.[425] The dimension of availability, also referred to as national food security, emphasises the production and existence of sufficient food and distribution networks.[426] Accessibility is defined at an individual level and determined by whether an individual has the economic or legal capacity to acquire food or produce it.[427] This, Brand argues, could be through the ability to earn an income, entitlement to social assistance or the ownership of land and/or the means of food production.[428] With regard to nutrition, Brand contends that the food that is available must be nutritionally adequate and possess the requisite amounts and balance of nutrients 'for physical and mental growth, development and maintenance, and physical activity'. Brand highlights that this nutritional dimension has been translated into a right to access safe food.

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[421] Khoza op cit note 324 at 667.
[422] *Wary Holdings (Pty) Ltd v Stalwo (Pty) Ltd and others* 2008 (11) BCLR 1123 (CC).
[423] Ibid at para 79.
[424] Ibid at footnote 79.
[425] Danie Brand 'Food' in Stu Woolman and Michael Bishop (eds) *Constitutional Law of South Africa* 2 ed RS 5 (2013) at 56C–3.
[426] Ibid.
[427] Ibid.
[428] Ibid.

An inherent limitation of Brand's analysis, however, is that it draws upon the content of a right to 'adequate food' but does not interrogate the distinction between the threshold of sufficiency against the standard of adequacy adopted in ICESCR and other international instruments. In fact, there is not much written about this distinction – perhaps understandably so, given that South Africa's Constitution is one of only five constitutions to set a threshold of sufficiency rather than adequacy for the right to food. [429] Of these five Constitutions, the Constitutional provisions for Bolivia, Niger, and the Gambia encompass a broader definition of the right to food by either supplementing the entitlement to 'sufficient food' with an additional entitlement to 'adequate food', or by containing the entitlement to food as a part of a composite set of entitlements.[430] Due to the differences in thresholds between the international right and South Africa's domestic one, it is necessary to understand the distinction between sufficiency and adequacy to give content to this right under the South African Constitution.

(b) Sufficiency versus adequacy under the South African Constitution

It is not clear why the right to food and water relates to sufficiency in section 27 when many of the other socio-economic rights (such as housing and healthcare) refer to adequacy, and thus adopt the standard enumerated in international instruments such as the UDHR and ICESCR.[431] When reviewing the Fourth Theme Committee reports on the right to food and the submissions received, it is also unclear why the phrasing of 'adequate nutrition' in the detainee's rights under the Interim Constitution was retained whilst the section 27 entitlement to food adopted a different threshold of sufficiency.[432] Cheadle and Davis suggest that the content of the General Comment and the standards applicable to adequacy can be transposed onto the concept of 'sufficiency' contained in section 27. The Oxford Dictionary supports the contention that adequacy and sufficiency might be interchangeable standards. Adequacy is defined as 'enough in quantity, or good enough in quality, for a particular purpose or need', while sufficient is similarly defined as 'enough for a particular purpose; as much as you need'.[433] However, the

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[429] This is according to a search of the Constitute Project database. Constitute 'Constitutions' available at https://www.constituteproject.org/constitutions?lang=en, accessed 27 July 2021.

[430] The Bolivian Constitution provides that 'The State has the obligation to guarantee food security, by means of healthy, adequate and sufficient food for the entire population.' The Gambian Constitutional provision reads, 'The State shall endeavour to facilitate equal access to clean and safe water, adequate health and medical services, habitable shelter, sufficient food and security to all persons.' The constitution of Niger: 'Each one has the right to life, to health, to physical and moral integrity, to a healthy and sufficient food supply [alimentation], to potable water, to education and instruction in the conditions specified by the law." The Zimbabwean constitution states: "everyone has the right to sufficient food'

[431] *Certification judgment* supra note 419 at para 76, where the Court engages in a brief discussion regarding the acceptability of the inclusion of certain rights which are not all universally accepted rights. Without elaborating as to which of these rights differ from those which are universally accepted, the Court briefly notes,

> 'Sections 26, 27 and 29 in the NT provide rights of access to housing, health care, sufficient food and water, social security and basic education. NT 28, among other things, provides such rights specifically to children. These rights were loosely referred to by the objectors as socio-economic rights. The first objection to the inclusion of these provisions was that they are not universally accepted fundamental rights. As stated, such an objection cannot be sustained because CP II permits the CA to supplement the universally accepted fundamental rights with other rights not universally accepted.'

[432] Oddly, the party submissions on this point from, for example the ANC, reference the UDHR standard of 'adequate food' but recommend the right be phrased as an entitlement to 'sufficient food'.

[433] JA Simpson *The Oxford English Dictionary: Vol. 1* (1991).

drafters of the Constitution chose to delineate a different scope for different rights, and the meaning of sufficiency must be considered in light of this.

The need for a distinction between sufficiency and adequacy is further compounded by the content of General Comment 12, which also delineates content specific to the sufficiency of food. The portion of the Comment which delineates the elements of the right to food draws a link between the sufficiency of food and dietary needs, food safety and acceptability. In this way, the Comment could be viewed as isolating the components of 'sufficient food' as dietary needs, food safety and acceptability. Similarly, Cheadle and Davis, relying on the Comment, suggest that the multi-faceted notion of sufficiency includes food that is 'culturally acceptable to a particular community', 'sufficient for nutritional needs in both quantity and quality', and 'safe', as well as being related to health and gender requirements.

The primary case law relating to the meaning of 'sufficient' within the context of section 27 is *Mazibuko*.[434] There, sufficiency of water supply was defined through national legislation regulating water services, and stipulating that water be provided of sufficient quantity and quality to support life and personal hygiene. [435] In the Supreme Court of Appeal, the applicants had successfully argued for the Court to set a minimum threshold of the water needed to 'lead a dignified life'.[436] Though the Constitutional Court did not make any particularly statements about the meaning or content of a right to sufficient water, the case turned in part on equality and equity in the distribution of water in the post-apartheid era.[437] These iterations of the content of the right to water all highlight the interdependence between this right and other rights, such as dignity, life and equality..

Other legislation and policies do offer definitions of sufficient food. The Marketing of Agricultural Products Act[438] appears to be the only legislation which contains a definition which might inform the meaning of sufficiency for food. 'Food security' is defined in the Act in terms of 'access, by all individuals, to sufficient food of sufficient quality, necessary for a healthy and active life'.[439] This definition ties the sufficiency and quality of food to a person's health and life.

There is a further section which may assist in elaborating the distinction between 'sufficient' and 'adequate'. Uniquely, the Constitution distinguishes between 'sufficient food' (in section 27) and 'adequate nutrition' (in section 35). Consequently, the content of the section 35 may be more aligned to that of a right to 'adequate food'. By understanding what bearing the content of the section 35 right has on the section 27 right, one may extrapolate which components of the international right to food are similarly transposed onto section 27. For this reason, a consideration of the ambit of the prisoners' rights versus the broader socio-economic right may also provide an additional lens through which to understand the distinction between sufficiency and adequacy.

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[434] *Mazibuko and Others v City of Johannesburg and Others* 2010 (3) BCLR 239 (CC); 2010 (4) SA 1 (CC)

[435] Section 1 of Water Services Act 108 of 1997 defines sufficient water in as 'the prescribed minimum standard of water supply services necessary for the reliable supply of a sufficient quantity and quality of water to households, including informal households, to support life and personal hygiene'.

[436] *Mazibuko* supra note 434 at para 51.

[437] Ibid at para 51.

[438] Marketing of Agricultural Products Act 47 of 1996.

[439] Section 1, Agricultural Products Marketing Act.

(c) The content of the right to food under section 28 – children's rights

Section 28 of the Constitution provides that 'every child has the right to basic nutrition, shelter, health care and social services, as well as the right to be protected from maltreatment, neglect, abuse or degradation'. This set of rights functions in a manner distinct from the other socio-economic rights in the Constitution, in that they are unqualified rights and, further, that primary responsibility for protection and fulfilment of the right lies with parents and caregivers rather than the state.[440] However, the state still bears some obligations under this right, as was recognised by the Constitutional Court in *Grootboom* and the *TAC* case:

> 'While the primary obligation to provide basic health care services no doubt rests on those parents who can afford to pay for such services, it was made clear in Grootboom that "[t]his does not mean . . . that the State incurs no obligation in relation to children who are being cared for by their parents or families." … The state is obliged to ensure that children are accorded the protection contemplated by section 28 that arises when the implementation of the right to parental or family care is lacking. Here we are concerned with children born in public hospitals and clinics to mothers who are for the most part indigent and unable to gain access to private medical treatment which is beyond their means. They and their children are in the main dependent upon the state to make health care services available to them.'[441]

This aligns with the content of the CRC as discussed above, which outlines the state's obligation to adopt measures the assist parents and caregivers to fulfil this right, including the provision of social assistance.[442] Though the discussions in *Grootboom* and the *TAC* case related to housing and healthcare, this applies equally to the right to basic nutrition.

There are important differences between the general right to food and the operation of the children's rights in section 28, and this Chapter does not purport to provide a comprehensive discussion of the children's right to food. Rather, it considers briefly whether the right to basic nutrition can assist in provide a HR anchor for NCD prevention. As with other constitutional rights and other conceptualisations of the right to food, the section 28 right to basic nutrition is not a standalone right to be considered in isolation from other entitlements. Perhaps more so than in respect of other rights, there have been clear and definitive statements that the children's right to basic nutrition is central to the realisation of other rights. There is a recognised interdependence between a child's access to food and their ability to experience and realise their rights to health and education.[443]

The individual components of section 28 are underscored by the requirement to give paramount consideration to the best interests of the child. This interdependence was recognised as a means to given practical effect to childrens rights by Mills in analysing the role of section 28 in the context of marketing restrictions.[444] As Mills put it, the State has an obligation to not

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[440] Julian May,Chantell Witten, Lori Lake et al 'The slow violence of malnutrition' *South African Child Gauge 2020* at 38-9.
[441] *TAC* supra note 302 at paras 77-9 (references omitted).
[442] Article 27(3) of the CRC.
[443] May et al op cit note 398 at 39.
[444] Lize Mills, 'Considering the best interests of the child when marketing food to children: an analysis of the South African Regulatory Framework' (2016) unpublished thesis, University of Stellenbosch at 75.

only assist parents of the child but to ensure that members of the broader community consider the best interests of the child when acting in particular way.[445] This provides an even stronger basis to justify, if not outright compel State action to protect and promote these rights. In this sense, efforts to address NCDs can then rely on both the children's rights to health and basic nutrition as well as the best interests of the child as a self-standing right.[446]

This interdependence as an underpinning to protect children's interests is perhaps most clearly illustrated in *Equal Education v Minister of Basic Education*,[447] which concerned the suspension of the National School Nutrition Programme (NSNP) during the COVID-19 pandemic and the associated lockdown which resulted in the closure of schools. The core constitutional question in this case was whether the NSNP fell within the ambit of the right to basic nutrition under section 28(1)(a), and whether the state was entitled to suspend the programme. In respect of the first question, the Court went to great lengths to explain the interrelationship and interdependence of the rights to education, nutrition and health.[448] The Court noted that in government policies on the NSNP, the link between the rights to education, health and food are made explicit, with the purposes of the NSNP stated to include: 'contribut[ing] to the improvement of education quality by enhancing … learning capacity, school attendance and punctuality… [and] general health development by alleviating hunger'. [449] The Court also highlighted the role of food insecurity and hunger in contributing to adverse health conditions, including obesity and micronutrient deficiencies, something which the NSNP assisted in ameliorating.[450] The Court went on to find that the NSNP was part of the state's constitutional obligations under the children's right to basic nutrition.[451]

In light of the finding that the NSNP was part of the fulfilment of the right to basic nutrition, its suspension was then held to be a retrogressive measure. Due to the unqualified nature of the right, the bar to justify this retrogressive step is high:

> 'Section 28(1) of the Constitution is only qualified with the word "basic" and no internal qualifier. The failure to roll out the NSNP is thus justifiable only in terms of the criteria and proportionality analysis required by the general limitation clause of section 36. The rights to basic nutrition can thus also not be progressively realised. Furthermore, the State is a bearer of positive obligations in respect of the rights contained in the Bill of Rights. But the Constitution also creates a negative obligation not to impair the right of access to the rights in our Constitution. The State accordingly has a duty to respect and protect entitlement to basic nutrition and education as fulfilled by the NSNP.'[452]

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[445] Ibid at 3.
[446] Ibid at 98.
[447] *Equal Education and Others v Minister of Basic Education and Others* 2021 (1) SA 198 (GP).
[448] Ibid at paras 34-41.
[449] Ibid at para 36 referring to White paper on Reconstruction and Development 1994.
[450] Ibid at para 30 which reads:

> 'The severity of high levels of unemployment leads to poverty and consequently to food insecurity. Even when employed, the income is not adequate with the informal sector employment totalling 5 million, who in turn supports 16 million people. The parents can accordingly not provide sufficient food and nutrition to their children. Children who suffer from hunger are at risk of various forms of malnutrition which include wasting, stunting, obesity and micronutrient deficiencies'.

[451] Ibid at para 42.
[452] Ibid at paras 43-4.

This case highlights two integral components of the children's right relevant to supporting NCD prevention measures. The first is that it underscores the interrelated nature of the rights contained in section 28, expressly recognising that there are links between nutrition and health, and, specifically, that there is an obligation on the state to address nutrition and to prevent the diseases that emanate from malnutrition, including obesity. The second is that the state bears a higher burden in justifying a failure to discharge their obligations under section 28 than the justification provided in terms of section 36 of the Constitution as the justification relies on resource constraints. Particularly where children have been provided with a certain entitlement, the rolling back of that entitlement would be considered retrogressive. This is important in the context of nutrition transition and may provide a basis upon which existing access to healthier or less harmful foods may be preserved on the basis that reduced access to these foods may be considered retrogressive in the context of the right to basic nutrition.

(d) The right to food under section 35(2)(e) – prisoner's rights

Defining the content of the rights contained in section 35(2) can be complex. It is generally understood that prisoners are entitled to certain rights, but, by virtue of their incarceration and corresponding vulnerability, it is also understood that section 35(2)(e) may afford them stronger constitutional protections than ordinary citizens.[453] In the case of accessing medical treatment and healthcare services, prisoners have been entitled to more immediate access to treatment at the expense of the state than would otherwise be the case.[454] While the immediacy of the obligation is greater, the content of the right to adequate medical treatment has largely been limited to primary healthcare services, indicating a more limited content for the section 35 right than under section 27(1)(b).[455]

Under section 35(2)(e), there is thus a tension between the more limited content of the entitlement and the 'higher duty of care' borne by the state.[456] Recognising that the infringement of section 35(2)(e) rights cannot be justified on the basis of budgetary constraints, Brand J in *Van Biljoen*, held that the determination of what constitutes 'adequacy' is influenced by the context of the situation, stating:

> 'I do not, however, agree with the proposition that financial conditions or budgetary constraints are irrelevant in the present context. What is "adequate medical treatment" cannot be determined in vacuo. In determining what is "adequate", regard must be had to, inter alia, what the State can afford. If the prison authorities should, therefore, make out a case that as a result of budgetary constraints, they cannot afford a particular form of medical treatment or that the provision of such medical treatment would place an unwarranted burden on the State, the Court may very well decide that the less effective medical treatment which is affordable to the State must in the circumstances be accepted as "sufficient" or "adequate medical treatment". After all, as was pointed out by Mr Scholtz, section 35(2)(e) of the Constitution does not provide for

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453 Nasreen Motala and David McQuoid-Mason 'Do Prisoners in South Africa Have a Constitutional Right to a Holistic Approach to Antiretroviral Treatment?' (2013) 6 *South African Journal of Bioethics and Law* 40 at 41.
454 Ibid.
455 Ibid at 42. See also the decisions in *B and Others v Minister of Correctional Services and Others* 1997 (6) BCLR 789 (C); *Du Plooy v Minister of Correctional Services and Others* 2004 JOL 12850 (T); *EN and Others v Government of the Republic of South Africa and Others* 2007 (1) All SA 74 (D).
456 Ian Currie and Johan De Waal *The Bill of Rights Handbook* (2013) at 748.

> "optimal medical treatment" or "the best available medical treatment", but only for "adequate medical treatment"'.[457]

This is distinct from the position applicable to the broad socio-economic rights where the content of the right is not limited by resource constraints while the enforcement of the right may be.[458] In other words, the content of the rights contained in section 35 are more limited than those contained in sections 26 and 27. The converse is then that the obligations articulated as part of the section 35 right are also a minimum floor on the content of the socio-economic rights. In this sense, one might consider that under section 35(2)(e), the state has a duty to ensure that, in a narrower sense, prisoners receive the nutrition they require to survive whether in the form of food or otherwise; by contrast, under section 27, individuals outside the prison system have the autonomy to make choices regarding the types of food they consume and exercise greater freedom in the composition of the diet. The state's obligation in that instance could be argued to be one of ensuring that consumers are in a position to access food sufficient to exercise this autonomy, as well as the content of the narrower prisoner's right to access adequate nutrition.

However, the prisoner's entitlement to food was demonstrated to be broader than the provision of adequate nutrition alone. In *Huang*, the applicants sought a concession to receive special food relating to an Eastern diet whilst in prison. In support of this, the applicants relied on section 27(1)(b) to argue that they had a right to be provided with a special diet. The Court, per Kruger J, did not specifically consider the section 27(1)(b) right to food, but rather the detainee's right to adequate food read with section 8 of the Correctional Services Act 111 of 1998. It concluded that religious requirements and cultural preferences ought to be accommodated.[459] The Court also made reference to the residuum principle in support of this finding, stating:

> 'The common-law principle is that a sentenced prisoner retains all the basic rights and liberties of an ordinary citizen except those taken away from him by law, expressly or by implication, or those necessarily inconsistent with the circumstances in which he, as a prisoner, is placed. Hoexter JA describes this as the "Innes dictum" and says the following: "The Innes dictum serves to negate the parsimonious and misconceived notion that upon his admission to a gaol a prisoner is stripped, as it were, of all his personal rights; and that thereafter, and for so long as his detention lasts, he is able to assert only those rights for which specific provision may be found in the legislation relating to prisons, whether in the form of statutes or regulations. The Innes dictum is a salutary reminder that in truth the prisoner retains all his personal rights save those abridged or proscribed by law. The root meaning of the Innes dictum is that the extent and content of a prisoner's rights are to be determined by reference not only to the relevant

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[457] *Van Biljon and Others v Minister of Correctional Services and Others* 1997 (4) SA 441 (C) at para 49.

[458] *Grootboom* supra note 306; *Soobramoney* supra note 294.

[459] *Huang & others v Head, Grootvlei Prison & another* [2008] JOL 21089 (O) at paras 24-5 where the court states:

> 'The relevant section for prisoners in the Constitution is section 35(2)(e) which provides that every sentenced prisoner is entitled to the provision, at State expense, of adequate nutrition. Section 8 of the Correctional Services Act 111 of 1998, as amended by the Correctional Services Amendment Act 32 of 2001, deals with nutrition of prisoners. Section 8(3) provides as follows: "Where reasonably practicable, dietary regulations must take into account religious requirements and cultural preferences." This section embodies a policy which is in line with the Constitution'.

> legislation but also by reference to his inviolable common-law rights." This is the residuum principle: whatever rights have not been taken away, remain.'[460] (References omitted.)

Though this reasoning was not explicitly linked to section 27(1)(b), this aspect of the right to food which accommodates a prisoner's religion and culture could broadly fit within the 'acceptability' dimension of the right to food.[461] The implication of this reference and reliance on the residuum principle is that the right to culturally acceptable food is one that detainees had prior to their detention and which persists during their detention. In this way, the statements around an entitlement to culturally and religiously acceptable food can be seen as applicable to the content of the section 27 right.

Reading the content of the residuum principle as supplemental to the section 35(2)(e) allows for the importation of the content of the right to 'adequate' food into the content of section 27(1)(b), while recognising that the content of the right to 'sufficient' food is more expansive than this too. Based on this, we can conceive of the right to sufficient food containing a right to adequate food that is also culturally and/or religiously acceptable, as well as encompassing obligations related to food production and availability, as per *Wary Holdings.*

This then enables us to draw on the content of nutritional adequacy developed under international law and which was discussed above as having very clear linkages to the prevention of diet-related NCDs. As a consequence, the requirement that 'sufficient food' be nutritionally adequate and not result in consumers developing food-related illnesses can be imported into the content of section 27(1)(b), thus resolving the question of whether South Africa's right to 'sufficient food' encompasses these issues of nutritional adequacy.

V. THE CONTENT OF A RIGHT TO NUTRITIOUS AND HEALTHY FOOD UNDER THE CONSTITUTION: THE INTERRELATIONSHIP BETWEEN THE RIGHT TO FOOD AND OTHER CONSTITUTIONAL RIGHTS

> 'The right to food is essential to human survival and a precondition for the enjoyment of all rights and freedoms. Its violation amounts to the infringement of an array of rights.'[462]

Recognising that, in substance, the right to access healthy food under section 27(1)(b) contains much of the content of the international right to food, as discussed above, the question of what the content of the right to sufficient food is in relation to nutrition remains. As has been discussed in the previous Chapter, food is often considered an underlying determinant of health, and the conceptualisation of the right to health that includes nutrition and food aligns with the content of the right to health under international law.

This interplay between multiple rights is also recognised in General Comment 12, which states that the realisation of the right to food is contingent upon the fulfilment of other rights. As is acknowledged by General Comment 12, it is difficult for an individual to cook and consume safe food without clean water, electricity and shelter. There is also a clear

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[460] Ibid at paras 26-27.
[461] Acceptability is not expressly outlined in the General Comment 12 but a dimension of 'cultural acceptability' of food is recognised.
[462] Khoza op cit note 357 at 666–7.

relationship between the realisation of other rights and the right to food. Under regional instruments, international law and in foreign jurisdictions, clear links have been drawn between the right to food and one's ability to lead a dignified life. Translating this into the framework of the Bill of Rights requires us to locate different facets of this determinants-based right within existing socio-economic rights. This section will explore how the constitutional right to sufficient food may be imbued with health-related considerations and be developed to encompass the nutritional content of food and its impact on the health of South Africans.

Based on *Huang*, it is apparent that the content of the right to food is informed by other rights. Beyond this, there is a level of interdependence between the rights contained in the Bill of Rights which was articulated clearly in *Grootboom*:

> 'Our Constitution entrenches both civil and political rights, and social and economic rights. All the rights in our Bill of Rights are inter-related and mutually supporting. There can be no doubt that human dignity, freedom and equality, the foundational values of our society are denied those who have no food, clothing and shelter. Affording socio-economic rights to all people therefore enables them to enjoy the other rights enshrined in Chapter 2.'[463]

Brand places this interrelationship between the right to food and other rights at the fore, stressing that this interdependence is particularly true for the right to food.

> 'In short, the right to food is more or less embedded in other rights - measures to give effect to it are intertwined with measures to give effect to other rights, and its violation is often inseparable from the violation of a range of other rights. As a consequence, the right to food is seldom directly protected, whether through legislation or adjudication. More often it is indirectly protected through another constitutional right or lower level entitlement – to see the right to food in operation, one also has to look there.'[464]

Furthermore, many of the policy solutions suggested by Brand to address the 'crisis' of undernutrition are of equal utility in making healthier food more available, such as expanding VAT zero-rating of basic foodstuffs and social safety net programmes such as food stamps and grants.[465] This underpins the close relationship between under- and over-nutrition in South Africa, and how solutions lie in improving the quality and nutritional sufficiency of the food system.

When expounding on the direct relationship between the right to food and other rights, Brand goes further in drawing explicit links between a person's health and the realisation of the right to food:

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[463] *Grootboom* supra note 306 at para 23.

[464] Brand op cit note 359 at 164–5.

[465] Brand op cit note 357 at 9 where the type of action required both in the short and long-term is expounded upon as follows:

> '*Grootboom* and the *TAC* case say that government is obliged to take account of the needs of such people. The basic policy imperative for the direct transfer of food to those in crisis can now be framed in legal terms. I would suggest that extensive measures providing for the direct transfer of food, be it through extended tax zero-rating on basic foodstuffs, Food price controls of another kind, food stamps, extended monetary social assistance, or the actual provision of food, are constitutionally required in the light of *Grootboom*, in addition, of course, to longer-term income and Food production generation and other capacity building strategies. By implication, a policy framework that makes no or only negligible provision for these kinds of measures would be unreasonable because it is exclusive and inflexible. As such it would be unconstitutional.'

> 'Possibly more so than any other socio-economic right, the right to food is dependent for its realisation on realising a range of other rights. This is true in an indirect sense: Simply to acquire food, one needs, for example, access to land, to education and resultant employment and income generation and, in some instances, to social security or assistance … It is also true, more importantly, in a direct sense. Research has shown that a person's ability to be nourished by food physically acquired and ingested "depends crucially on ... characteristics of a person that are influenced by such non-food factors as medical attention, health services, basic education, sanitary arrangements, provision of clean water, land, eradication of infectious epidemics".'[466]

Brand goes even further, however, by linking the content of the entitlement to food with health, contending that diseases may 'create extra requirements for realising the right to food' where they give rise to deficiencies or require a particular type of nutrition as a part of their treatment.[467] As has been discussed above, there is clear recognition within international law that the nutritional composition of food is central to its sufficiency, and that nutrition is a core component of the right to food as well as the realisation of other rights (such as the right to life and health). Against this, Brand's propositions are helpful to inform and delineate the role of nutritional sufficiency in the constitutional right to food. South African case law on socio-economic rights, and specifically in respect of food, also supports the contention that nutrition and the impact that it has on the realisation of other rights has constitutional protection and that there is a right to nutritious food within the framework of the Bill of Rights. But how does the right to access sufficient food apply within the context of food environments that have a proliferation of unhealthy food leading to obesity and associated diseases?

Here too, Brand's conceptualisation of obligations arising from section 27(1)(b) are helpful. Brand contended that South Africans who were unable to access food and thus suffered from undernutrition could be understood to be experiencing 'nutritional deprivation'. In this framing, Brand contends that the government is required to take action to address the needs of these individuals under *Grootboom* and the *TAC* cases.[468] As has been discussed above, the malnutrition that gives rise to NCDs stems from the nutritional inadequacy of available and accessible foods or the lack of nutrition security. Conceptualised in this manner, Brand's contention is that the government is obliged to take action to meet the needs of nutritionally deprived persons, including those who experience malnutrition in the form of lack of access to healthy foods.

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[466] Ibid at 10.

[467] Ibid where it is stated: 'Brand goes further in linking the right to food with the right to health, as follows:

> "to use basic examples, a person suffering from a simple disease such as diarrhoea, caused by contaminated water, is unable to ingest the nutrients and calories of food eaten. In this way the right to food is compromised by deficiencies in realising the right to water. A person who suffers from malaria requires, among other things, additional quantities of iron - failures in health because of disease create extra requirements for realising the right to food. A person who is insufficiently educated is unable to obtain the full benefit of food acquired because of a lack of knowledge about how to store or prepare it optimally. A final example that is perhaps at this stage more poignant for South Africans is the following: the right to food of a new-born child of an HIV positive mother is directly implicated by its mother's health, as the current policy of the National Department of Health is to discourage breastfeeding in such a situation, without at the same time providing substitute feeding. Realising the child's right to food in this case is determined to a large extent by a failure in realising its mother's right to health (which prevents breast feeding), as well as the socio-politically informed health policy decision not to provide substitute feeding"'.

[468] Ibid at 9.

In his concurring judgment in *Soobramoney*, Sachs J explored in some detail the notion that a healthy life is predicated upon the coalescence of a multitude of factors that contribute to good health, and argued that there is a need to imbue healthcare rights with these additional factors. Though he did not specifically refer to food, he mentioned a number of other antecedents to good health such as water and sanitation, stating:

> 'Health care rights by their very nature have to be considered not only in a traditional legal context structured around the ideas of human autonomy but in a new analytical framework based on the notion of human interdependence. A healthy life depends upon social interdependence: the quality of air, water, and sanitation which the state maintains for the public good; the quality of one's caring relationships, which are highly correlated to health; as well as the quality of health care and support furnished officially by medical institutions and provided informally by family, friends, and the community. As Minow put it: "Interdependence is not a social ideal, but an inescapable fact; the scarcity of resources forces it on us".'[469]

The previous Chapter discussed in detail the extent to which the right to healthcare under section 27(1)(a) may be used to support disease prevention interventions, including in the context of NCDs. The interrelationship between healthcare and other rights provides a basis upon which to imbue these rights with content that creates a right to health. In this regard, the right to sufficient food, and specifically the obligations related to nutrition, can be read to create an entitlement for individuals to have access to sufficient and nutritionally adequate food that will not result in diseases, including NCDs. There is thus a corresponding obligation on the state to protect, promote, fulfil and formulate a response to the right to sufficient food that would include ensuring that the food made available and accessible is nutritionally adequate. Further, in the context of the right to healthcare, there is an obligation to take measures to prevent diet-related NCDs to reduce the burden on the healthcare system, even where these measures may sit outside the healthcare system.

VI. CONCLUSION

This Chapter has outlined the content of the right to food contained in section 27(1)(b) in relation to NCD prevention, specifically identifying components of the right that could be supportive of NCD prevention measures. Central to informing the content and application of the right to food is the recognition that the realisation of this right is interrelated with, and heavily dependent on, the protection and realization of other rights. Similarly, the right to healthcare as discussed in Chapter 3 can be afforded some content if read with other rights. In this manner, the rights to food and health can be read together to create obligations and entitlements for NCD prevention. It is then necessary to clarify what obligations fall on the state to address NCDs under these supportive rights. Consequently, the next Chapter will attempt to concretise what obligations arise from these rights.

[469] *Soobramoney* supra note 294 at para 54.

CHAPTER 5
OBLIGATIONS ARISING UNDER THE HUMAN RIGHTS APPROACH TO NCDS

I. OBLIGATIONS UNDER SOCIO-ECONOMIC RIGHTS IN THE BILL OF RIGHTS

The socio-economic rights contained in the Bill of Rights, specifically under sections 26 and 27, are enforceable and justiciable, imposing concrete obligations on both the state and private actors.[470] At the outset, there was recognition that sections 26 and 27 imposed a 'negative obligation' on 'the state and all other entities and persons to desist from preventing or impairing the right of access to adequate housing' and that this negative obligation 'applies equally to the section 27(1) right of access to "health care services, including reproductive health care"'.[471]

Beyond this negative obligation, socio-economic rights are also subject to progressive realisation which imposes an obligation on the state to 'take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of this right'.[472] Within the context of section 27, this has been interpreted to mean that under sub-section (1), everyone is afforded a right of access to various entitlements such as food, water and healthcare services, and that under sub-section (2) the state is obliged to take reasonable steps to achieve the progressive realisation of these access rights.[473] This has also been framed as the 'positive obligations' that attach to these rights. This obligation toward progressive realisation is constrained by the availability of resources, and thus the rights themselves have been interpreted as limited by this lack of resources.[474] This is the internal limitation placed on socio-economic rights which is evaluated by the reasonableness standard.[475]

The Constitutional Court has interpreted sub-sections 27(1) and 27(2), when read together, as giving rise to an obligation on the state to 'respect, protect, promote and fulfil' the right to healthcare and the other socio-economic rights contained in the Constitution. These 'respect, protect, promote and fulfil' obligations have varying content which will be explored and concretised later in this Chapter. The protect and respect obligations that arise from these sections differ to some extent from the other positive obligations and consist of, at a minimum, the state's duty to refrain from interfering with an individual's enjoyment of the right and to prevent others from similarly interfering. Sometimes termed 'negative obligations', these are

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[470] *Certification judgment* supra note 419 at para 78.
[471] *TAC* supra note 302 at para 46.
[472] Sections 26(2) and 27(2) of the Constitution.
[473] *TAC* supra note 302 at para 30.
[474] *Soobramoney* supra note 294 at para 11 which reads, 'What is apparent from these provisions is that the obligations imposed on the State by ss 26 and 27 in regard to access to housing, health care, food, water and social security are dependent upon the resources available for such purposes, and that the corresponding rights themselves are limited by reason of the lack of resources.'
[475] Kevin Iles 'Limiting Socio-Economic Rights: Beyond the Internal Limitations Clauses' (2004) 20 *South African Journal on Human Rights* 448 at 455.

not always subject to the same internal limitation as the other positive obligations which are subject to progressive realisation.[476]

The decision in *Grootboom* elaborated on the mechanisms the state may employ to meet its obligations under various socio-economic rights (which include legislative and other measures such as policies and programmes) and considered the standard to be used in assessing whether the positive obligations are met, stating:

> 'The State is required to take reasonable legislative and other measures. Legislative measures by themselves are not likely to constitute constitutional compliance. Mere legislation is not enough. The State is obliged to act to achieve the intended result, and the legislative measures will invariably have to be supported by appropriate, well-directed policies and programmes implemented by the Executive. These policies and programmes must be reasonable both in their conception and their implementation. The formulation of a programme is only the first stage in meeting the State's obligations. The programme must also be reasonably implemented. An otherwise reasonable programme that is not implemented reasonably will not constitute compliance with the State's obligations.'[477]

These all have relevance to the present discussion, given the varying structures and mechanisms employed in NCD prevention. It also worth noting that while socio-economic rights give rise to obligations to address NCDs in various ways, these obligations and the rights themselves are subject to limitation. For socio-economic rights, these limitations arise both under the general limitations clause contained in section 36 of the Constitution, and within the internal limitation of progressive realisation subject to available resources contained within the provisions of section 26 and 27.

In the preceding Chapters, it has been established that the section 27 rights to healthcare and food have content that can encompass and buttress NCD prevention efforts. Centrally, the argument of the preceding Chapters is that NCD prevention measures contribute to the indirect protection of the right to healthcare under section 27(1)(a), and the fulfilment of the right to sufficient food under section 27(1)(b) (in respect of content related to nutrition and healthfulness of food). If the stipulated content of these rights is accepted, the next question concerns the obligations that arise under these rights in relation to NCD prevention obligations. At the outset, the rights under section 27 are distinct from the other entitlements such as those encompassed within section 35 and 28 because they are fundamentally access rights.[478] However, as has been discussed in the preceding Chapters, there are multiple facets to the obligations that arise under section 27 based on the content of the right to food and right to healthcare.

II. OBLIGATIONS UNDER THE RIGHT TO HEALTHCARE

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[476] Ibid at 460, where Iles outlines how, at a practical level, there is also a higher standard of review applied to the negative duty to respect socio-economic rights – particularly where other rights or particularly vulnerable groups are implicated.

[477] *Grootboom* supra note 306 at para 42.

[478] Siyambonga Heleba 'The Right of Access to Sufficient Water in South Africa: How Far Have We Come?' (2011) 15 *Law, Democracy & Development* at 263.

In Chapter 3, the operation of the right to healthcare in the context of supporting broader public health interventions was discussed in some detail. The core contention of this Chapter was that the right to healthcare is afforded a broad ambit where interventions operate to reduce the burden on the public healthcare system and thus *protect* the right of access to healthcare of the broader population. This obligation and its ambit were discussed extensively in Chapter 3, and the basis for this contention will therefore not be reiterated here. In summary, however, the obligations that emanate from the right to healthcare have been defined under existing case law as consisting of an obligation on the government to protect. In this regard, the government can regulate and constrain the activities of third parties where their conduct may lead to an increased burden on the healthcare system. However, this obligation in itself may need to be buttressed by further rights to enable government to justifiably limit other rights in its endeavour to protect. Further, while this obligation offers a basis to justify government's actions, it has only limited value in providing a means to compel and guide further action. For this reason, it is necessary to expound upon the obligations that may arise from the right to food to support NCD efforts, and to thereby delineate where HR may provide guidance and accountability.

III. OBLIGATIONS UNDER THE RIGHT TO HEALTHY FOOD

At the outset it must be acknowledged that the lack of litigation and enforcement of the right to food presents a challenge to concretising the enforceable obligations that arise from the right. This difficulty is compounded by the highly interdependent nature of the right to food with other rights. Echoing the interdependence espoused by Brand, Nkrumah notes that the right to food is often realised through the realisation of other rights, and is thus not often directly enforced in laws and case law.[479]

In terms of General Comment 12, the availability and accessibility of food (including physical and economic accessibility) are core components of the right to food. These components have also been accepted as part of the South African right to health. In addition, the right to food also gives rise to obligations to ensure that food is safe, culturally acceptable and, as argued in Chapter 4, nutritionally sufficient. When adjudicating the obligations that arise from the socio-economic rights, Yacoob J in *Grootboom* reiterated that these obligations fit within the 'respect, protect, promote and fulfil' rubric outlined in section 7 of the Constitution, stating:

> 'Socio-economic rights are expressly included in the Bill of Rights; they cannot be said to exist on paper only. Section 7(2) of the Constitution requires the state "to respect, protect, promote and fulfil the rights in the Bill of Rights" and the courts are constitutionally bound to ensure that they are protected and fulfilled. The question is therefore not whether socio-economic rights are justiciable under our Constitution, but how to enforce them in a given case.'[480]

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[479] Nkrumah op cit note 324 at 55 where he states:

> 'Akin to other socioeconomic rights, the RTF [right to food] is tied to other fundamental rights and freedoms… Thus, an obvious solution for providing greater access to sufficient food lies in improving access to these ancillary rights in ways that might positively impact on sections 27 and 28 of the Constitution. … It was against this backdrop that Brand and Heyns avow that the RTF often finds protection through other constitutional rights, given that it is often not directly safeguarded by law or court rulings.'

[480] *Grootboom* supra note 306 at para 20.

Table 3 draws on the nutritional and food security matrix developed by Eide, Oshaug & Eide[481] to locate these facets of the right to food within the respect, promote, fulfil rubric enumerated in ICESCR and adopted under section 8 of the Constitution. The content of these obligations is outlined in more detail below.

Table 3: Right to Food Obligations for NCD prevention under the Respect, Protect, Promote and Fulfil Framework

	Nutritional Adequacy	**Safety**	**Cultural Acceptability**	**Availability**	**Accessibility**
Respect	Recognise the positive nutritional aspect of existing food patterns	Provide mechanisms to address violations of food safety codes	Create awareness and social acceptability of traditional diets	Refrain from creating conditions which promote production of unhealthy foods	Preserve existing pathways of accessing nutritious food (whether informal or formal) Refrain from creating conditions which promote disease and epidemics through proliferation of unhealthy food
Protect	Prevent private actors from displacing healthier food items with unhealthy foods		Limit the influence of private actors in changing the acceptability of traditional diet and promotion of unhealthy foods	Regulate food production to ensure private food production is meeting the population needs	Regulate private actors to ensure the pricing and accessibility of foods is adequate and sufficient is available to the population
Promote	Prevent distortions of positive nutritional aspects of existing food patterns	Create / improve food standards Mandatory reformulation to remove harmful nutrients from food	Counteract influences which may negatively erode positive aspects of existing food culture	Incentivise production of healthier foods	Making health food choices more financially accessible to low-income groups
Fulfil	Correct negative aspects of existing food patterns; guide dietary change when necessary	Improve understanding of healthfulness of foods and harms from unhealthy nutrients	Incorporate positive aspects of food culture into relevant development activities	Allow food production at a community / individual level	Provide mechanisms to make food financially accessible

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[481] Asbjorn Eide, Arne Oshaug and Wenche Barth Eide 'The Food Security and the Right to Food in International Law and Development Symposium: The Global Food Regime In the 1990s: Efficiency, Stability and Equity' (1991) *Transnational Law & Contemporary Problems* 415; Arne Oshaug, Asbjorn Eide and Wenche Barth Eide, 'Human Rights: A Normative Basis for Food and Nutrition-Relevant Policies' (1994) 19 *Food Policy* 491.

		Create an effective mechanism for food control and inspection			
Adapted from the Food Security Matrix[482] and Nutrition Security Matrix[483]					

(a) Physical accessibility

The Comment as well as various scholars have stated that the root of food insecurity, and malnutrition more generally, is not primarily a lack of food but rather a lack of access thereto.[484] Consequently, accessibility of food is central to the realisation of the right. Accessibility consists of both economic and physical/geographical dimensions of food access to different people. Physical accessibility requires that people are physically capable of accessing food, including those who are physically vulnerable such as infants, young children and those who are disabled. Particularly disadvantaged groups may require special attention or priority consideration in accessing food.

This dimension of physical access to food has unique applicability to the South African context when viewed through the lens of apartheid spatial planning. O'Regan J acknowledged this 'unequal access' in relation to water and its historical origins in *Mazibuko*, stating:

> Although rain falls everywhere, access to water has long been grossly unequal. This inequality is evident in South Africa. While piped water is plentifully available to mines, industries, some large farms and wealthy families, millions of people, especially women, spend hours laboriously collecting their daily supply of water from streams, pools and distant taps … The achievement of equality, one of the founding values of our Constitution, will not be accomplished while water is abundantly available to the wealthy, but not to the poor.'[485]

These difficult and burdensome obstacles to accessing water, particularly for the urban poor, are mirrored in accessing food.[486] The reality is that '[f]ood choice is therefore not simply a matter of personal choice, but also of urban design'.[487] Due to the difficulties in accessing transport, difficulties in physically accessing food substantially overlap with the economic dimensions of accessibility of food.[488] Under General Comment 12, economic accessibility requires that the personal or household financial costs to acquire the food needed for an adequate diet should not be so high as to threaten or compromise the attainment or satisfaction of other basic needs.[489] Even as the food environment changes, it has been shown that these areas are the most neglected in providing access to healthier foods.[490] Instead, there is a

[482] Eide, Oshaug and Eide op cit note 481 at 452.
[483] Oshaug, Eide and Eide op cit note 481 at 512.
[484] Brand op cit note 357 at 2.
[485] *Mazibuko* supra note 434 at para 2.
[486] Jane Battersby and Milla McLachlan 'Urban Food Insecurity: A Neglected Public Health Challenge' (2013) 103 *South African Medical Journal* 716 at 718.
[487] Ibid.
[488] Ibid.
[489] General Comment 12 at para 13.
[490] Battersby and McLachlan op cit note 486 at 717.

saturation of unhealthy food outlets in predominantly poor black areas.[491] In many instances, the number of fast food outlets vastly outnumbers the availability of grocery stores in these areas. To this end, there are physical accessibility obligations under the right to access food that are not currently being fulfilled.

(b) Economic accessibility

Poor urban populations in South Africa are compelled to economise in their food choices not only due to the lack of availability of certain kinds of food, but also due to structural factors that make preparing food unfeasible in many poorer households.[492] Unhealthy foods have become substantially cheaper and more accessible than healthy options (where these are even available at all). In this sense, one consequence of malnutrition – over-nutrition – is not linked to the accessibility of food per se, but rather to the content of the food made accessible or inaccessible to different populations.

As a result, when considering the prevention of food-related NCDs in the context of the right to food, the aspects involved are distinct from the typical conceptualisation of the right to food focused on food availability and accessibility. Instead, NCD prevention is concerned with trying to reduce access to cheap, appetizing yet harmful foods and instead make healthy foods with better nutritional content more available and accessible. For these reasons, accessibility of food needs to be understood and realised in concert with other components of the right to food to ensure both that the right to food is realised and to prevent other rights from being diminished by unhealthy or nutritionally insufficient food. Expanding access to food that is not nutritionally sufficient or is unsafe for consumption over the long term is thus unlikely to meet the state's obligations to protect and realise the right to food.

(c) Nutritional adequacy

In addition to the nutritional deprivation framing which places access to insufficient healthy food as a component of physical and economic access, there is a component of nutritional adequacy within the right to food that also gives rise to certain obligations. Meier and Ayala have framed this obligation in terms of the intersection between the rights to food and health, arguing 'that food be adequate to the extent that it addresses nutrition as an underlying determinant of health – expanding consideration of adequacy beyond caloric sufficiency to include nutritional standards'.[493]

Consequently, the obligations to ensure access to nutritionally adequate food do not emanate solely from the right to food, but from the intersectional and supportive reading of the right to healthcare with this right. As discussed in detail in Chapter 3, the right to healthcare may be indirectly protected through the adoption of measures outside the healthcare system, where these measures aim to reduce the burden of disease. This reading can be used to support the adoption of extensive NCD prevention measures, even those seated outside the domain of

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[491] Ndlovu et al op cit note 372.
[492] Jane Battersby and Maya Marshak *Mapping the Invisible: The Informal Food Economy of Cape Town, South Africa* (2017).
[493] Ayala and Meier op cit note 183 at 12.

healthcare. In particular, measures that aim to improve the quality of diet and reduce consumption of unhealthy food contribute to improving the nutritional adequacy of an individual's diet and thus serve to protect, promote and realise the right to food.

(d) Obligation to protect

(i) Private actors as duty bearers under a human rights approach to NCDs

According to Nygren-Krug, a HR-based approach offers particular value in addressing the complexity of the NCD epidemic because it offers a mechanism to guide action and an opportunity to build the capacity of both rights holders and duty bearers to realise these rights.[494] A HR-based approach thus provides a mechanism for accountability and outlines how a state's failure to take action can constitute a violation of its obligation to protect the right to health.[495] This is expounded upon by utilising the HR-based approach to identifying who duty-bearers and beneficiaries should be. From the perspective of international law, the primary duty-bearers remain states, but when concretised to a domestic legal system one can use the HR-based framework to identify a multiplicity of actors – across various sectors of government, private actors such as donors, multinational corporations and producers of commodities that lead to NCDs.[496] In this regard, states or governments may have a responsibility to promote and protect HR implicated in increasing NCD prevalence, and to regulate private actors to ensure they act in compliance with HR obligations.[497]

International	Government	Private Actors
• States as prime duty bearers under international law • International bodies such as World Health Organisation	• Health • Agriculture • Finance • Education • Media and Communication • Trade and Industry • Transportation • Social Development	• Multinational Corporations • Food, sugar, tobacco and alcohol industries • Donors

Figure 3:Duty bearers under a Human Rights-based approach to prevention and control of NCDs developed from Nygren-Krug's description of potential duty bearers.[498]

Debate continues regarding the relationship between HR and private actors, particularly businesses, multinational corporations and producers of harmful commodities. In some respects, these actors are beneficiaries under HR obligations and have some entitlements under these. However in other respects, the activities these actors engage in may undermine HR, specifically the right to health. As a starting point to manage this complexity in the context of NCD prevention, Nygren-Krug suggests the use of the 'protect, respect, and access to remedy'

[494] Nygren-Krug op cit note 122 at 264.
[495] Ibid at 269.
[496] Ibid at 265.
[497] Ibid.
[498] Ibid.

framework developed by Ruggie.[499] The most developed aspect of this framework under international law is the protect component.[500] In the context of NCDs, for example, the CESCR found that 'failure to discourage production, marketing and consumption of tobacco' constituted a violation of the right to health, and this finding could then support regulation at a domestic level.[501] There have not, however, been similar statements regarding other modifiable risk factors such as alcohol, ultra-processed foods or sugar.

Table 4: Protect, Respect, Remedy Framework as applied to NCD prevention

Framework Component[502]	**Protect**	**Respect**	**Access to Remedy**
General Duty[503]	Governments remain primary duty bearers tasked with ensuring that domestic policies include HR across these sectors.	Companies are primary 'targets' of the duty or corporate responsibility to 'do no harm'.	There ought to be an effective remedy available to those who suffer rights violations.
NCD specific considerations[504]	Given the cross-sectoral nature of determinants of NCDs, there is a need to ensure that, across all sectors, government actions consider the prioritisation of HR objectives, specifically health-related when dealing with businesses	When applied in the context of NCDs, this principle may be incongruent with the very existence and operation of the business as some products are inherently and exclusively harmful to consumers, such as tobacco.	Enforcement of domestically recognised health rights through the judicial system.

(ii) The application of negative obligations to private actors

There has been clear recognition that, at a minimum, private actors are subject to negative obligations under sections 26 and 27, as seen in the *TAC, Grootboom* and *Certification* judgments. In *Grootboom* specifically, the Court held: "[a]lthough [section 26(1)] does not expressly say so, there is, at the very least, a negative obligation placed upon the state and all other entities and persons to desist from preventing or impairing the right of access to adequate housing'.[505]

In the context of the right to food, the *SERAC* decision also discussed the obligations the right places on both private actors and government. Here, the obligations were framed in terms of the government's obligation to protect the right, with the Commission finding that the failure to prevent private actors from interfering with citizens' rights to food meant that the government fell foul of its obligation to protect the right to food:

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[499] Ibid at 268.
[500] Ibid at 270.
[501] General Comment 14 at para 1.
[502] John Ruggie 'Protect, Respect and Remedy: A Framework for Business and Human Rights' (2008) 3 *Innovations: Technology, Governance, Globalization* 189 at 192.
[503] Ibid.
[504] Nygren-Krug op cit note 122 at 269–71.
[505] *Grootboom* supra note 306 at para 34.

> 'Without touching on the duty to improve food production and to guarantee access, the minimum core of the right to food requires that the Nigerian Government … should not allow private parties to destroy or contaminate food sources, and prevent peoples' efforts to feed themselves. The government's treatment of the Ogonis has violated all three minimum duties of the right to food. The government has destroyed food sources through its security forces and state oil company; has allowed private oil companies to destroy food sources; and, through terror, has created significant obstacles to Ogoni communities trying to feed themselves. The Nigerian Government has again fallen short of what is expected of it as under the provisions of the African Charter and international human rights standards, and hence, is in violation of the right to food of the Ogonis.'[506]

Yang et al noted the import of this obligation to protect when considering the activities of private actors, emphasising the need to utilise this obligation to regulate the harmful behaviour of trans-national corporations:

> 'A similar transformation of moral to political and legal human rights claims on TNCs is more challenging; TNCs are obligated first and foremost to their fiduciary responsibility to corporate investors. Thus, the state role as protector of human rights against third party violations is essential, requiring greater state responsiveness to rights claims made by people and communities who are vulnerable to developing NCDs vis-à-vis corporate interests. This can be brought about only if power is more evenly distributed among stakeholders. Thus, a structural approach conceives of the right to health as something that can be claimed against governments, industry, and other duty-bearers for the development of and investment in NCD prevention and control policies and programs.'[507]

There is support, at a minimum, for this type of action to emanate from section 27 obligations. It is possible for the obligations imposed on private actors to extend even further than this, however. Jurisprudence on section 26 provides an indication that there may be positive obligations for private actors that emanate from socio-economics rights. However, the application of positive obligations to private actors in the context of the right to healthcare and food has not been developed. In light of this, it is sufficient to acknowledge that there is clear value in considering the potential of these obligations to support action on NCDs.

IV. CONCLUSION

This Chapter has brought together the content and obligations that emanate from the right to food and health under section 27 of the Constitution to guide and support NCD prevention measures, concretising the obligations that arise from these rights within the context of a HR framework. However, this is only the first step in developing a HR-based approach to NCD prevention in South Africa. The application of rights in a positive and supportive manner is an incomplete HR-based approach as it does not consider how rights may be limited or infringed by NCD prevention measures or in other ways impede public health efforts. The next Chapter will seek to address this component of a HR-based approach to NCDs by attempting to

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[506] *SERAC* supra note 270 at paras 66-7.
[507] Joshua S. Yang, Hadii M. Mamudu and Rijo John 'Incorporating a Structural Approach to Reducing the Burden of Non-Communicable Diseases' (2018) 14 *Globalization and Health* 66 at 70.

reconcile these positive and negative obligations within the framework of section 36 of the Constitution.

CHAPTER 6
THE RELATIONSHIP BETWEEN RIGHTS AND NCD PREVENTION – RECONCILING PUBLIC HEALTH AND HUMAN RIGHTS

I. INTRODUCTION

It is recognised that the interdependence of rights is not only a means to achieve rights: there is also a need to balance competing rights when fulfilling others. This is a particularly salient issue within the context of NCD prevention. As has been discussed in Chapter 2, many of the measures adopted to prevent NCDs can restrict, limit or otherwise negatively affect other rights. In the context of the rights to food and healthcare as supportive rights attached to NCD prevention interventions, a tension emerges between those rights being protected and promoted through the intervention, on the one hand, and those being limited by the intervention on the other – these may include rights such as the right to freedom of expression, trade and others.

Where there are multiple rights implicated in an intervention, and these rights are both supportive of and limited by the intervention, Rautenbach invokes the concept of 'colliding rights'. In such a situation, it is necessary to balance those rights in the context of a limitations analysis.[508] The greater the degree to which other rights are promoted by a measure, Rautenbach explains, the more easily the limitation on a right may be justified. He frames this in terms of a principle articulated as '[t]he greater the degree of non-satisfaction of, or detriment to, one principle, the greater the importance of satisfying the other', and further that '[t]he principles referred to in this formulation can for our purposes be described as, on the one hand, the right that has been limited and, on the other hand, the interests or rights protected or promoted in terms of the purpose of the limitation'.[509]

Sachs J articulates a similar viewpoint regarding the limitation of rights that flows from the interdependence of rights, stating in *Soobramoney*:

> 'Traditional rights analyses accordingly have to be adapted so as to take account of the special problems created by the need to provide a broad framework of constitutional principles governing the right of access to scarce resources and to adjudicate between competing rights bearers. When rights by their very nature are shared and inter-dependent, striking appropriate balances between the equally valid entitlements or expectations of a multitude of claimants should not be seen as imposing limits on those rights (which would then have to be justified in terms of section 36), but as defining the circumstances in which the rights may most fairly and effectively be enjoyed.'[510]

The concept of colliding rights is of particular importance in the light of the constitutional rights framing adopted in this thesis. It has been argued in the preceding Chapters

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[508] Ian Rautenbach 'Proportionality and the Limitation Clauses of the South African Bill of Rights' (2014) 17 *Potchefstroom Electronic Law Journal* 2228 at 2250.
[509] Ibid.
[510] *Soobramoney* supra note 294 at para 54.

that NCD prevention measures are supported by, inter alia, the right to healthcare and food, and in this context the section 36 analysis is influenced not only by the rights impugned by the intervention but also the degree to which rights are protected and promoted by the resulting limitation.[511] This informs the consideration and weighing of the 'importance of the purpose of the limitation' under a section 36 analysis as, where the measure seeks to exercise, protect or promote another right, this influences the importance of the purpose of the limitation. This issue forms the central concern of this Chapter, which examines how these 'colliding rights' should be treated in the context of an epidemic such as the NCD epidemic.

Despite the number of regulatory and legislative interventions adopted to address NCDs There has been no jurisprudence directly on the resolving the tensions that arise in the context of NCD prevention measures. However, as has been discussed in Chapter 3, jurisprudence and scholarship on resolving the tension between public health objectives and competing rights may be informative of how this tension can be resolved. While many of the earlier cases focussed on bio-medical interventions and access to the healthcare system, the jurisprudence that developed during the COVID-19 pandemic provides an ideal case study to examine how tensions between colliding rights are resolved in the context of NPIs and other interventions which seek to achieve public health objectives.

This Chapter attempts to address the limitation of rights resulting from NCD prevention interventions through the lens of colliding rights. Much of this is dependent, however, on the relationship between NCD responses and constitutional rights, and how the tension between public health objectives and constitutional rights ought to be managed. For this reason, how the relationship between public health and rights is framed is of central concern – a question this Chapter seeks to explore. However, it must be acknowledged that the concept of colliding rights represents only one frame of the relationship between human rights. Consequently, before one can resolve tensions between colliding rights, one must first understand the relationship between public health and human rights in its many facets. For this reason, the chapter begins by discussing the relationship between HR and public health more broadly by drawing on the frames developed by Mann and identifying three phases of this relationship historically. This provides a baseline to understand the role of section 36 in resolving the tension of 'colliding rights' or justifying a limitation. Next, I outline how the relationship between public health and constitutional rights has been framed in previous jurisprudence on epidemics, specifically HIV, TB and non-communicable diseases, including tobacco. Thereafter, substantial attention is given to the way this relationship functioned during the COVID-19 pandemic as a case study which offers a means to understand how this relationship has been framed in a contemporary epidemic. The Chapter concludes by drawing lessons from COVID-19 jurisprudence which can be used to address the NCD epidemic.

The varying approaches to HR and NCDs illustrate the strong relationship between the way in which these concepts interact and how the epidemic has been framed. The type of framing adopted can significantly impact whether rights serve as supports or impediments to NCD prevention. Though the conceptualisation of rights as impediments to NCD interventions

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[511] Rautenbach op cit note 508 at 2250.

has been a dominating frame, this thesis has demonstrated how rights may be supportive of these prevention efforts. This Chapter will thus adopt a multi-faceted conceptualisation of this relationship. While rights can be supportive, there remains a need to consider the resulting incursions on individual liberty that flow from the adoption of these interventions. Further, whether and how these incursions can be integrated into and reconciled with a HR-based approach to NCDs must be explored. These incursions should be reflected upon critically and understood within the broader complex relationship between NCDs, individual rights and the structural determinants of health. It is also necessary to consider whether the genuine limitations of rights that arise from NCD prevention efforts can be justified under the South African Constitution.

For the remainder of this Chapter, I will consider the historical relationship between public and HR as a conceptual framework to explore and understand the relationship between NCDs and HR. Specifically, this Chapter will consider how 'colliding rights' – the confluence of supportive rights and the limitation of rights – ought to be managed within the context of NCD prevention measures. Thereafter, there will be an analysis of how HR and public health measures have been balanced in South African jurisprudence broadly, both within the context of NCDs and, most recently, during the COVID-19 pandemic. The Chapter will conclude by drawing out the ways in which the relationship between NCD prevention and HR can been understood and how tensions can be reconciled,

II. THE ROLE OF HUMAN RIGHTS IN PUBLIC HEALTH RESPONSES

(a) A historical overview

Tensions often emerge between individual HR and the achievement of public health objectives. Sometimes measures adopted in response to disease outbreaks can limit HR in the name of public health objectives.[512] Restricting freedom of movement and trade during a lockdown, for instance, aims to reduce human mobility through which disease is spread. This approach was particularly prevalent in traditional public health responses to communicable diseases.[513] Extreme measures such as isolating ships and the people on board for 40-days to prevent the spread of the Black Death during the 1300s (while also perversely preventing their access to food and water),[514] and the creation of stigmatised and under-serviced leper colonies illustrate these tensions.[515] Modern approaches to disease control recognise that HR and public health efforts can complement each other, however, especially where efforts work towards the realisation of the right to health.[516] This can manifest through improved access to healthcare and infrastructure, improved disease surveillance and reporting, and the implementation of improved methods to control the spread of disease.[517] States have obligations under HR

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[512] Benjamin Mason-Meier, Dabney P. Evans and Alexandra Phelan 'Rights-Based Approaches to Preventing, Detecting, and Responding to Infectious Disease' in Mark Eccleston-Turner and Iain Brassington (eds) *Infectious Diseases in the New Millennium* (2020) 217 at 250.

[513] Lawrence O. Gostin and Lindsay F. Wiley *Public Health Law* (2016) at 13–5.

[514] Philip A. Mackowiak and Paul S. Sehdev 'The Origin of Quarantine' (2002) 35 *Clinical Infectious Diseases* 1071 at 1072.

[515] Julie H. Levison 'Beyond quarantine: a history of leprosy in Puerto Rico, 1898-1930s' (2003) 10 *História, Ciências, Saúde-Manguinhos* 225 at 226.

[516] Gostin op cit note 42 at 245; Mann et al op cit note 110 at 8.

[517] Meier, Evans and Phelan op cit note 512 at 253.

principles, including the right to health, to respond to and control epidemics and outbreaks within their borders (and, some argue, beyond their borders).[518] Consequently, efforts to realise HR to health can be understood as complementary to public health responses to communicable diseases. After all, where public health goals are achieved, healthy individuals see their right to health, life, bodily integrity and dignity being fulfilled.

In other respects, certain HR and modern public health goals (and associated mechanisms) may still stand in tension with each other. In South Africa, for instance, a criminal prohibition on spreading fake news concerning COVID-19 was introduced. Here there is a clear limitation on the individual's right to freedom of expression, though this limitation may be seen as justifiable under section 36 of the Constitution given the potential harms caused by misinformation, including the potential to compromise public health. A public health measure therefore has to be justifiable according to the domestic laws of the implementing country. Public health measures interact with the standard machinery of society (everyday laws, policies, behaviours and freedoms) by both promoting certain rights and, on occasion, limiting – or even infringing – others. While this interplay has existed since the development of quarantine restrictions and the birth of modern public health regulations, it was viewed for the first time through the HR framework during the HIV/AIDS epidemic, when the right to privacy was used to prevent discrimination against vulnerable groups, including homosexual men.[519]

In recent years, the spread of diseases across national borders has become the subject of particular concern, and has often caused panic in areas trying to prevent an outbreak.[520] This has lead to disproportionate public health measures being implemented, including trade and travel restrictions (with travellers at times being placed under invasive quarantines).[521] During the COVID-19 epidemic, the South African government also introduced criminal offences that sanctioned those who exposed people to the virus, a measure that had a disproportionate impact on poorer communities that could not observe social distancing and hygiene measures due to overcrowding and poor sanitation infrastructure.[522] If not adopted correctly, measures such as these can often perpetuate stigmatisation and discrimination associated with outbreaks of communicable diseases. Further tensions exist in the realm of public health measures aimed at the detection of diseases. The use of compelled testing can run contrary to the principles of informed consent, and disclosure of such information can infringe on the right to privacy. This raised particular concerns during the COVID-19 epidemic, where efforts to scale up testing in South Africa included compelled testing.[523]

The above discussion has considered how interventions to control the spread of communicable diseases can infringe upon or limit individual rights. It is important to recognise

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[518] Ibid.
[519] Ibid.
[520] James G. Hodge Leila Barraza, Gregory Measer et al 'Global Emergency Legal Responses to the 2014 Ebola Outbreak: Public Health and the Law' (2014) 42 *Journal of Law, Medicine & Ethics* 595 at 597.
[521] David Fidler 'From International Sanitary Conventions to Global Health Security: The New International Health Regulations' (2005) 4 *Chinese Journal of International Law* 325 at 390.
[522] Safura Abdool Karim 'Criminalisation of Transmission of SARS-CoV-2: A Potential Challenge to Controlling the Outbreak in South Africa' (2020) 6 *South African Medical Journal* 110 at 112.
[523] Petronell Kruger 'Compelled Testing for the Novel Coronavirus' (2020) 110 *South African Medical Journal* 1 at 2.

that these measures, while limiting the individual rights of affected people, also work to protect a number of other rights, particularly those linked to the social determinants of health such as the rights to work, education, dignity and life – and the collective right to health of the broader population.[524] The right to health places certain obligations on states to respect, protect and fulfil the health of individuals.[525] Part of the state's duties under this framework are to prevent, detect and control outbreaks of infectious diseases within their borders, to assist in preventing them from spreading outside their borders, and, arguably, to assist other states to prevent, detect and control outbreaks where assistance is needed.[526] This requires that states develop the capacity to detect outbreaks, to report these outbreaks at the local, regional, national and international levels, and to respond to the outbreak with treatments, vaccines and other public health measures. There is also a need, however, to consider the HR implications of these public health measures. States have a fundamental role in realising HR for health by ensuring that any public health measure enacted is complimentary to HR obligations. In this context, it is critical for states to adopt the least restrictive measures that achieve the necessary public health goal while limiting the impact on individual rights. This includes implementing measures that respect individual rights as far as possible, and which are grounded in evidence rather than perception. This approach seeks to ensure minimal interference with HR, minimising the effects of HR infringements that can serve to undermine public health efforts, including stigma and mistrust in public health systems.[527]

(b) The three phases of the relationship between human rights and public health responses

When reflecting on the history of public health responses to epidemics and HR, it is possible to view this history as having three distinct phases. These can be used to understand the different ways in which HR and public health responses interact and how judicial systems may approach tensions between these. The three phases are discussed chronologically in this section, but as will become apparent in later sections of this chapter, their application to real world public health crises is not homogeneous – often courts and governments can apply these phases simultaneously or even regressively within epidemics.

The first phase, termed the 'non-recognition of HR phase', can be understood as an approach to public health divorced from HR concerns more broadly. In this approach, public health objectives are given primacy with no regard to its impact on HR in general. Public health goals are not linked to the promotion of any HR, but seen as an exception or separate from HR. This approach persisted from the 14th century through to much of the 20th century, when public health measures were imposed to prevent the spread of disease without consideration of how these measures might impact on HR.[528]

The second phase, termed the 'conflict between rights and public health', emanates from advocacy surrounding the HIV epidemic which placed rights at the foreground of the

[524] Mann et al op cit note 110 at 8.
[525] Including under the UDHR and WHO Constitution.
[526] Gostin et al supra note 111 at 2734.
[527] Mann et al op cit note 110 at 8; Meier, Evans and Phelan op cit note 512 at 253.
[528] Fidler op cit note 521 at 390.

public health response.[529] In some instances, one could argue that public health objectives were rendered secondary to HR, particularly civil and political rights, with the efficacy of measures being diluted to ensure greater respect for the rights of infected persons. Broadly speaking, this conceptualisation of public health and HR sees the two concepts as mutually exclusive and in tension or conflict with one another. The fulfilment of HR may lead to compromises in public health responses or vice versa.

The third phase find its origins not in the application of HR to epidemic responses per se, but in a theoretical model which proposes viewing public health and HR as complementary and mutually reinforcing.[530] Given the interdependence of constitutional rights,[531] and specific interdependence between the right to health and other determinants of health,[532] it is argued later in this chapter that this complementary approach is most closely aligned with South Africa's constitutional dispensation and ought to be the approach adopted by our judiciary.

(i) Non-recognition of human rights

There have been efforts to control the spread of disease dating back centuries. Quarantine was initially used in efforts to combat the Black Death, yellow fever and other communicable diseases dating back to the 14th century, which involved separating infected individuals from the general populations.[533] Even before Louis Pasteur proposed germ theory that explained the science behind how diseases move from person to person, ports in Europe had been imposing quarantines on sailors entering their cities as a means of controlling the spread of disease.[534] Sailors would be held in isolation on neighbouring islands and observed to see whether they developed symptoms.[535] Similar measures, were adopted in cities to prevent the spread of cholera and yellow fever during the 19th century.[536] Yet these measures did not involve a coordinated response to outbreaks implemented by a government, but were instead implemented on an ad hoc basis.[537] Sanatoriums also emerged during the mid-19th century to isolate individuals from society who were infected with diseases like Tuberculosis (TB).[538]

Despite their historic origins, the use of restrictive measures such as isolation, quarantine and travel restrictions continue to form part of the modern armamentarium of public

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[529] Gostin et al supra note 111 at 2733.
[530] Mann et al op cit note 110 at 21.
[531] Lanse Minkler and Shawna Sweeney 'On the Indivisibility and Interdependence of Basic Rights in Developing Countries' (2011) 33 *Human Rights Quarterly* 351 at 396; Sandra Liebenberg and Beth Goldblatt 'The Interrelationship Between Equality and Socio-Economic Rights Under South Africa's Transformative Constitution' (2007) 23 *South African Journal of Human Rights* 335 at 361.
[532] Marius Pieterse 'The Interdependence of Rights to Health and Autonomy in South Africa' (2008) 125 *South African Law Journal* 553 at 572.
[533] Gostin and Wiley op cit note 513 at 16.
[534] Norman Howard-Jones 'The Scientific Background of the International Sanitary Conferences 1851 – 1938' *World Health Organisation Reports* (1975) at 9.
[535] Ibid.
[536] Ibid.
[537] Ibid.
[538] JR Bignall 'Treating Tuberculosis in 1905: The First Patients at the Brompton Hospital Sanatorium' (1977) 58 *Tubercle* 43 at 52.

health responses, key interventions during both the Ebola and COVID-19 epidemics.[539] While the use of quarantine and isolation still occurs today, historically, little consideration was given to the infringement of individual rights such as freedom of movement, individual autonomy and privacy in their implementation. In the early and mid-19th century, there were attempts by several nations to establish a base level of government response in dealing with outbreaks of disease, particularly cholera. In 1851, the International Sanitary Regulations (the ISR) were adopted at the International Sanitary Conference in Paris, laying the foundation for the creation of the WHO.[540] Given that there had been little to no recognition of HR during this time, however, the interplay between HR and public health was not considered in the formation of these documents. In this sense, though this first phase has its origins in the 14th century, it may find itself resurrected in public health crises.

(ii) Recognition of a right to health

The 1946 WHO Constitution provided the first recognition that health was a human right: 'the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being'. Even in this early conceptualisation of the right, the WHO Constitution recognised the right to health as more expansive than simply the 'absence of disease'; it was seen as an entitlement to 'the highest attainable standard of physical and mental health'. The UDHR was adopted in 1948 and created a set of universal rights which were to be goals for all nations and their citizens. Article 25 stated that '[e]veryone has the right to a standard of living adequate for the health and well-being of himself and of his family', and envisioned health as part of a set of interdependent HR including access to food, clothing, housing and social security. The ICESCR developed the right to health even further, recognising 'the right of everyone to the enjoyment of the highest attainable standard of physical and mental health' and mandating that states take steps to achieve the full realisation of these rights, including steps in relation to the 'prevention, treatment and control of epidemic, endemic, occupational and other diseases'.[541]

At the same time the ICESCR was established, the International Covenant on Civil and Political Rights was formulated, which included a range of civil and political rights and protections, including the right to self-determination and the right to the protection of physical integrity, liberty and security of persons. While there was provision for these rights to be limited, they could only be limited in a time of public emergency which threatened life. Consequently, the development of the right to health was paralleled with a growing realisation that public health measures, particularly those taken during public health emergencies, could limit other HR, specifically civil and political rights.[542] In 1984, the Siracusa Principles gave greater definition to the circumstances under which rights granted under the International Covenant on Civil and Political Rights could be limited.[543] Specific provision was made for

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538 Ibid.

540 Fidler op cit note 521 at 289.

541 Article 12 of the ICESCR.

542 Gostin et al op cit note 111 at 2732; Meier, Evans and Phelan op cit note 512 at 250.

543 Siracusa Principles on the Limitation and Derogation of Provisions in the International Covenant on Civil and Political Rights, 1985 E/CN.4/1985/4 (the Siracusa Principles).

using public health as a ground for limiting rights where there was a serious threat to the health of the population or individual members in that population.[544]

(iii) Rights in conflict with public health

Following the Declaration of Alma-Ata, which reaffirmed the centrality of the right to health in responding to public health crises, and with the burgeoning HIV epidemic in the 1980s, there was a transformation in the way HR were linked to public health responses.[545] When the HIV epidemic initially began, the nature of the virus was largely unknown. Its modes of transmission were unclear and there existed no means to treat it. Groups already marginalised and stigmatised in society, such as sex workers, people who inject drugs and men who have sex with men were at high risk of infection.[546] Fear pervaded public discourse and intense stigma developed around the disease. Discrimination against HIV-positive individuals continued to grow. This discrimination and stigma led to many people avoiding HIV tests.[547] Because there were no treatments, emphasis was placed on preventing the disease from spreading. Interventions for prevention focused on individual behaviours and, in some instances, placed limits on individual autonomy – by compelling individuals to get tested, for instance.[548]

As the epidemic progressed over the subsequent decades, a multiplicity of rights was infringed and violated, often with the effect of undermining public health objectives. For example, many countries introduced laws that criminalised the non-disclosure of one's HIV-status to sexual partners, or made HIV a notifiable condition, requiring national health authorities to be immediately informed of any positive patients. This increased the stigma around HIV.[549] Once treatments were developed, further forms of discrimination emerged as access to treatment often depended on one's economic status.[550] Governments in low resource settings would have to prioritise which patients could get access to treatment.[551] The stigma and fear surrounding the disease made people unwilling to get tested or disclose their status. The adoption of criminalisation statutes, and the fact that workplace discrimination was permissible, also disincentivised individuals from getting tested.[552] These issues were compounded by the fact that the disease disproportionately affected vulnerable populations. As a result, protecting the rights of vulnerable populations and the rights of HIV-positive persons

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[544] Ibid at article 25.
[545] Gostin et al op cit note 111 at 2732.
[546] Benjamin Mason-Meier, Kristen Nichole Brugh and Yasmin Halima 'Conceptualizing a Human Right to Prevention in Global HIV/AIDS Policy' (2012) 5 *Public Health and Ethics* 263 at 264.
[547] Sofia Gruskin, Edward J. Mills, and Daniel Tarantola 'History, Principles and Practice of Health and Human Rights' 370 (2007) *Lancet* 449 at 450.
[548] Patrick O'Byrne 'Criminal law and public health practice: Are the Canadian HIV disclosure laws an effective HIV prevention strategy?' (2012) 9 *Sexuality Research and Social Policy* 70 at 72.
[549] Scott Burris and Edwin Cameron 'The Case against Criminalization of HIV Transmission' 300 *Jama* (2008) 578 at 580.
[550] Christopher J Colvin and Mark Heywood 'Negotiating ARV Prices with Pharmaceutical Companies and the South African Government: A Civil Society/Legal Approach' in Ellen Rosskam & Ilona Kickbusch (eds) *Negotiating And Navigating Global Health: Case Studies In Global Health Diplomacy* (2011).
[551] Alan O. Sykes 'TRIPS, Pharmaceuticals, Developing Countries, and the Doha Solution Symposium: Public Health and International Law' (2002) 3 *Chicago Journal of International Law* 47.
[552] Burris and Cameron op cit 549 at 580.

became closely linked with achieving public health objectives. The inaccessibility of treatments to the majority of those affected defeated both public health and HR objectives.

In response to the challenges faced by marginalised groups and the negative influence of stigma and fear on efforts to control the epidemic, activists advocated for public health responses that respected HR.[553] This ultimately reshaped the relationship between public health and HR from one of inherent antagonism to a complementary approach where public health and the advancement of HR were often linked.[554] Thus, the goals of public health came to intersect and align with those of HR as the epidemic progressed. In this context, the defence of rights came to be seen as the primary priority, even if their enforcement undermined the efficacy of traditional, restrictive public health interventions.

Even the formulation of the right to health started to follow this more nuanced approach. In 2000, for instance, the Committee on Economic Social and Cultural Rights (CESCR) highlighted that the right to health includes concrete steps to prevent, control and treat epidemic diseases, including through the use of education programmes, epidemiological surveillance, data collection, and the implementation and enhancement of immunisation programmes.[555] This positioned public health measures not as limitations on rights, but as mechanisms – and even obligations – within the ambit of recognised rights.

(iv) A new way of thinking: public health and human rights as complementary?

The interrelationship between public health and HR that emerged during the HIV epidemic laid the foundation for viewing the two concepts as complementary. In practice, however, many continued to view public health interventions (particularly restrictive interventions) as antagonistic to HR.[556] In 1994, however, Mann et al proposed considering HR as a dimension of public health goals.[557] The three-part framework they developed explicitly included HR as part of the effort to address the epidemic and cemented the marriage of HR and public health.[558] Since its publication, this framework predicated on complementarity has become the touchstone for conceptualising a modern relationship between public health and HR.[559]

The first part of the framework outlines the relationship between a state's actions in respect of public health (such as policies, programmes and actions) and HR.[560] A state's responsibility in public health matters consists of three functions. The first function relates to

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[553] Mark Harrington 'From HIV to Tuberculosis and Back Again: A Tale of Activism in 2 Pandemics' (2010) 50 *Clinical Infectious Diseases* 260.
[554] Gostin et al op cit note 111 at 2735.
[555] General Comment 14 at para 16.
[556] For example, in Human Rights Committee 'General Comment No. 34 on Article 19 of the International Covenant on Civil and Political Rights' CCPR/C/GC/34 available at https://www.refworld.org/docid/4ed34b562.html, accessed 23 July 2021, the Human Rights Committee is quite clear in protecting opinions on all matters, including scientific opinions, and denounces the criminalisation of such opinions (para 9). This conflicts clearly with government restrictions and penalties on dis- and misinformation campaigns which have been widely implemented during the Covid-19 response globally.
[557] Mann et al op cit note 110 at 6.
[558] Ibid. at 11.
[559] Gostin and Wiley op cit note 513 at 16.
[560] Mann et al op cit note 110 at 11.

assessing the health needs and problems of the population, and developing and implementing responses to address these problems and needs.[561] The manner in which a state fulfils these functions can, however, result in violations of HR. A state may be deemed to infringe the right to physical integrity and security of the person through mandatory testing and treatment. The right to privacy may be violated through the release of personal information. A state's actions can even amount to discrimination where it fails to address the health problems of particularly vulnerable populations, or if it denies these populations access to care, adversely impacting the realisation of rights by marginalised groups.[562]

The second part of the framework considers the health impacts of HR violations, illustrated most clearly in the context of severe violations like torture or execution.[563] Mann et al contend, however, that virtually all HR violations can also have a negative impact on one's health, whether directly (such as in the case of unsafe working conditions, which can violate a right to work under 'just and favourable conditions' and result in serious injury, or even death, to employees) or through more indirect effects (as in how violations of the right to dignity may have a more diffuse, but still significant, impact on the health on individuals and communities).

The third part of the framework, a particularly novel component, argues that health and HR are complementary approaches to addressing and promoting human well-being. This link is particularly important when it comes to addressing the social determinants of health, such as poverty and inequality. In this way, Mann et al argue that the promotion and protection of HR is intrinsically linked to the protection and promotion of health.[564]

This Mannian understanding of the link between public health and other rights has seen some uptake by international bodies. The African Commission on Human and Peoples' Rights has acknowledged that 'Covid-19 carries profound HR consequences in the short to the long term',[565] linking public health interventions with a range of rights: the protection of the right to life; the right to enjoy the best attainable state of physical and mental health;[566] the right to access to information;[567] the right to be free from discrimination by taking into account the disproportionate impact of Covid-19 on the poor and unhoused.[568] It even acknowledges some of the longer term socio-economic impacts on society such as access to food.[569] The United

[561] Ibid.
[562] Ibid.
[563] Ibid.
[564] Ibid.
[565] Resolution on Human and Peoples' Rights as central pillar of successful response to COVID-19 and recovery from its socio-political impacts, ACHPR/Res. 449 (LXVI) (2020) available at https://www.achpr.org/sessions/resolutions?id=480.
[566] Ibid.
[567] African Commission on Human and Peoples Rights 'Press Statement on human rights based effective response to the novel COVID-19 virus in Africa' (2020) available at https://www.achpr.org/pressrelease/detail?id=483 which encourages measures to avoid the spread of mis- and disinformation.
[568] Ibid.
[569] Solomon Ayele Dersso 'Statement by Commissioner Solomon Ayele Dersso, Chairperson of the African Commission on Human and Peoples' Rights' (12 August 2020) available at https://www.achpr.org/pressrelease/detail?id=529, accessed 10 November 2021 which states:

Nations Human Rights treaty bodies similarly acknowledged the impact of COVID-19 not simply on the right to life, bodily integrity and health. It recognised the wide-ranging effects of the pandemic: the exacerbation of discriminatory practices against women (specifically the girl-child) and refugees in the realms of social assistance, labour and education;[570] the rights of persons with disabilities to access food and supportive services which might be interrupted by COVID-19;[571] general disruptions to the food system and consequent price hikes;[572] and even the impact on community and cultural life.[573]

Using Mann et al's framework to consider the interplay between health and HR in the context of communicable diseases, the importance of adjusting public health measures to include HR as a means of improving health overall is shown clearly. In practice, this conception of complementarity does not always function as Mann et al conceptualised and, in certain instances, public health measures may conflict with certain rights, not just function to realise them.

There is an underlying thread that can also enable one to localise the broader conceptual model described above to the South African context – namely, the operation of proportionality in each of the phases. At a conceptual level, the three phases are concerned with the manner in which the proportionality of a public health response is assessed. Phase 1 gives regard primarily to the severity of the epidemic or public health concern and perhaps, to a limited extent, whether the interventions will be effective in addressing the thread. Phase 2 is concerned with whether the public health benefits can justify incursions on HR, framing this in terms of requiring a justification for the infringement of rights (and thus linking to the section 36 limitations analysis which takes place when rights are limited). Phase 3 may not be incompatible with a section 36 analysis, but it does not frame the issues as rights versus health. In section 36

> 'Fourth, it has become clear that the unprecedented nature of the impact of COVID-19 not only on health but also other areas of life means that this pandemic is not a temporary event that will easily pass in a short time. Most notably, the socio-economic and humanitarian fall out of COVID-19 is widespread and severe. For us, the African Commission, perhaps this is one of the most serious and more enduring challenges that can have catastrophic human rights consequences as tens of millions are pushed to extreme poverty and many others face hunger and starvation.'

Although it should be noted that it is unclear whether the Commissioner was referring solely to the impact of the Covid-19 response.

[570] UN Committee on the Protection of the Rights of All Migrant Workers and Members of their Families and the UN Special Rapporteur on the human rights of migrants 'Joint Guidance Note on the Impacts of the COVID-19 Pandemic on the Human Rights of Migrants' (26 May 2020) available at https://www.ohchr.org/Documents/Issues/Migration/CMWSPMJointGuidanceNoteCOVID-19Migrants.pdf, accessed 10 November 2021.

[571] *United Nations Office of the High Commissioner*, 'Joint Statement: Persons with Disabilities and COVID-19 by the Chair of the United Nations Committee on the Rights of Persons with Disabilities, on behalf of the Committee on the Rights of Persons with Disabilities and the Special Envoy of the United Nations Secretary-General on Disability and Accessibility' (1 April 2020) available at https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=25765&LangID=E, accessed 10 November 2021.

[572] *Committee on Economic, Social and Cultural Rights,* 'Statement on the coronavirus disease (COVID-19) pandemic and economic, social and cultural rights' (6 April 2020) available at https://www.ohchr.org/Documents/HRBodies/CESCR/STM_COVID19.docx, accessed 10 November 2021.

[573] Ibid.

analysis, Phase 3 may be framed as balancing competing rights against each other, or perhaps weighing them collectively as mutually reinforcing.[574]

The remainder of this Chapter will consider the issue of 'colliding rights' in the context of measures to improve public health in the context of South African jurisprudence on public health. In particular, the conceptual framework of non-recognition, conflicting and complementary framings of the relationship between public health and HR will be used to analyse this jurisprudence and to understand how efforts to improve public health have interacted with rights. The next section considers how health-related cases have managed this relationship and whether there is support for a particular framing of this relationship within our jurisprudence.

III. SOUTH AFRICA JURISPRUDENCE ON HUMAN RIGHTS IN EPIDEMICS

Though the rights implicated in any public health response can be expansive, this section focuses specifically on case law related to previous epidemics in South Africa.

The jurisprudence developed during the HIV/AIDS epidemic became a touchstone for a HR-based approach to the epidemic, and played a significant role in concretising the role of HR in public health responses globally.[575] In *TAC*, the Constitutional Court recognised both the severity of the HIV epidemic as well as the government's competing duties to realise other socio-economic rights, stating:

> 'We are also conscious of the daunting problems confronting government as a result of the pandemic. And besides the pandemic, the state faces huge demands in relation to access to education, land, housing, health care, food, water and social security. These are the socio-economic rights entrenched in the Constitution, and the state is obliged to take reasonable legislative and other measures within its available resources to achieve the progressive realisation of each of them.'[576]

In the context of this case, these rights were to some extent viewed as competing rather than complementary and mutually reinforcing. However, the case was nonetheless of significant importance because the judiciary intervened to compel the state to provide treatment. Though the Court recognised the need to defer to the other branches of government, it also definitively rejected the applicability of the 'non-recognition of rights' phase in the context of South Africa's democracy. The court outlined its duty to intervene, even in the context of a pandemic, as follows:

> 'The primary duty of courts is to the Constitution and the law, "which they must apply impartially and without fear, favour or prejudice". The Constitution requires the state to "respect, protect, promote, and fulfil the rights in the Bill of Rights". Where state policy is challenged as inconsistent with the Constitution, courts have to consider whether in

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[574] Katharine G. Young 'The Right-Remedy Gap in Economic and Social Rights Adjudication: Holism Versus Separability' (2019) 69 *University of Toronto Law Journal* 124 which has a comprehensive discussion of how rights may be considered holistically when adjudicating rights-based challenges.
[575] Peris Jones *AIDS Treatment and Human Rights in Context* (2009); Mark Heywood 'Shaping, Making and Breaking the Law in the Campaign for a National HIV/AIDS Treatment Plan' in *Democratising development: The politics of socio-economic rights in South Africa* (2005), 181.
[576] *TAC* supra note 302 at 94.

> formulating and implementing such policy the state has given effect to its constitutional obligations. If it should hold in any given case that the state has failed to do so, it is obliged by the Constitution to say so.'[577]

In *Goliath*, the High Court had to determine whether it could order the forced isolation of a patient with Extensively Drug-Resistant Tuberculosis (XDR-TB) who had refused to be voluntarily isolated. The Court adopted a purposive interpretation of the Act to allow the 'involuntary isolation of patients with infectious diseases at a state-funded healthcare facility'.[578] In determining whether to order the forced isolation of the patient, it recognised that justifying such an order required balancing the individual's rights against those of broader society, giving consideration to the protection of the lives and health of those who could contract XDR-TB from the respondent.[579] The Court acknowledged that compulsory isolation would amount to a deprivation of freedom.[580] In conducting its section 36 limitations analysis, the Court placed significant weight on international and foreign laws that allowed compulsory isolation as well as the public health consequences of allowing XDR-TB to spread and the seriousness of the illness.[581] The decision in *Goliath*, specifically the section 36 limitations analysis has been subject to criticism, with Pieterse and Hassim arguing that the judge failed to adequately weigh the rights limited and accepted the contentions of the government without much critical analysis.[582]

Other decisions, however, such as the *S v Nyalangu*[583] and *Phiri v S*[584] judgments, adopt an approach which fails to recognise any role for HR. In *Nyalungu*, the Court was asked to consider whether an HIV-positive man who raped a woman was also guilty of the crime of attempted murder. It held that Mr Nyalungu was indeed guilty and imposed a life sentence. The Court recognised that it was presented with a novel issue and, in effect, was developing common law principles relating to criminal law. Section 39(2) of the Constitution clearly mandates courts, when 'interpreting any legislation, and when developing the common law or customary law [to] promote the spirit, purport and objects of the Bill of Rights'. Despite this clear injunction and the Court's recognition of the novelty and precedent-setting value of the judgment, the Court failed to consider the rights of the accused, while also failing to consider the broader public health implications of criminalising the transmission of HIV as attempted murder. In *Phiri*, Mr Phiri was appealing against a conviction of attempted murder after he failed to disclose his status as HIV positive to a sexual partner. The High Court did not comment or show any concern of its further development of the crime of attempted murder and only erroneously stated that 'it was established over a decade ago by this court that such conduct constitutes attempted murder' – it seems that a misreading of the Nyalungu judgment occurred.[585]

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[577] Ibid at para 99.
[578] *Goliath* supra note 309 at para 5.
[579] Ibid at para 35.
[580] Ibid at para 37.
[581] Ibid.
[582] Ibid.
[583] *S v Nyalungu* 2013 2 SACR 99 (T) 1.
[584] *Phiri v S* 2013 ZAGPPHC 279; 2014 (1) SACR 211.
[585] Ibid at para 6.

When exploring the impact HIV had on HR, *Hoffmann v South African Airways*[586] highlighted the role of HR in addressing stigma and discrimination against HIV-positive persons. The Constitutional Court recognised HIV as a ground of discrimination and then highlighted how the courts should address a conflict between a human right to equality and what South African Airways claimed to be an effort to protect Hoffman's health.[587] The Court further stated:

> 'The appellant is living with HIV. People who are living with HIV constitute a minority. Society has responded to their plight with intense prejudice. They have been subjected to systemic disadvantage and discrimination. They have been stigmatised and marginalised. As the present case demonstrates, they have been denied employment because of their HIV positive status without regard to their ability to perform the duties of the position from which they have been excluded. Society's response to them has forced many of them not to reveal their HIV status for fear of prejudice. This in turn has deprived them of the help they would otherwise have received. People who are living with HIV/AIDS are one of the most vulnerable groups in our society. Notwithstanding the availability of compelling medical evidence as to how this disease is transmitted, the prejudices and stereotypes against HIV positive people still persist. In view of the prevailing prejudice against HIV positive people, any discrimination against them can, to my mind, be interpreted as a fresh instance of stigmatisation and I consider this to be an assault on their dignity. The impact of discrimination on HIV positive people is devastating. It is even more so when it occurs in the context of employment. It denies them the right to earn a living. For this reason, they enjoy special protection in our law.'[588]

Another approach which prioritised the rights of HIV-positive persons was adopted in *NM v Smith,* which concerned how the right to privacy of HIV-positive persons were infringed when their names were disclosed in a book written by the respondent.[589] The Court highlighted the interrelationship between this private information and other rights such as the right to bodily integrity and personal autonomy. It again emphasised the particular context of HIV in South Africa and the stigma faced by HIV-positive persons.[590] The Court went further, however, and recognised the complementary role that protecting privacy rights may have in encouraging people to seek treatment and thus improve public health, stating:

> 'The disclosure of an individual's HIV status, particularly within the South African context, deserves protection against indiscriminate disclosure due to the nature and negative social context the disease has as well as the potential intolerance and discrimination that result from its disclosure. The affirmation of secure privacy rights within our Constitution may encourage individuals to seek treatment and divulge information encouraging disclosure of HIV which has previously been hindered by fear of ostracism and stigmatisation. The need for recognised

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586 *Hoffmann v South African Airways* [2000] ZACC 17; 2001 (1) SA 1; 2000 (11) BCLR 1211.

587 Ibid at para 30 where the Court outlines SAA's contention that the applicant was unfit to work as a flight attendant due to his HIV positive status, as follows:

> 'SAA refused to employ the appellant saying that he was unfit for world-wide duty because of his HIV status. But, on its own medical evidence, not all persons living with HIV cannot be vaccinated against yellow fever, or are prone to contracting infectious diseases - it is only those persons whose infection has reached the stage of immunosuppression, and whose CD4+ count has dropped below 350 cells per microlitre of blood. Therefore, the considerations that dictated its practice as advanced in the High Court did not apply to all persons who are living with HIV.'

588 Ibid at para 28.

589 *NM and Others v Smith and Others* [2007] ZACC 6; 2007 (5) SA 250 (CC); 2007 (7) BCLR 751 (CC).

590 Ibid at para 40.

> autonomy and respect for private medical information may also result in the improvement of public health policies on HIV/AIDS.'[591]

Through these cases, the Constitutional Court has explicitly rejected a non-recognition approach to HR in the context of a pandemic. Broadly, more recent decisions appear to adopt a complementary approach to HR and public health that aligns closely to Mann et al's framework. This accords with the broader view of the Court, which conceptualises constitutional rights, particularly socio-economic rights, as interdependent. We now turn to consider whether the courts followed this line of jurisprudence in the context of the COVID-19 epidemic.

(a) The role of human rights in South Africa's NCD jurisprudence

Section (ii) in Chapter 3 discussed in detail the limited case law on NCDs in South Africa. I will not seek to repeat this discussion here but will briefly reiterate the key points that emerge from the *BAT* case, specifically in respect of limiting constitutional rights. The *BAT* case concerned whether the limitations of the right to freedom of expression placed on tobacco producers by the ban on advertising tobacco products could be justified. In the High Court, the importance afforded to the public health purpose of the ban was held to clearly override the right to freedom of expression by Phatudi J, where he stated:

> 'I am of a strong, view that protection of "public health interest" is one of the fundamental rights that override the interest of an individual including that of the applicant. The right to freedom of expression is not absolute and cannot override the interest of the democratic society.'[592]

In applying the proportionality test – even where the ban was not framed as promoting other rights – the public health basis of the ban could thus be sufficient to limit individual rights.

The Supreme Court of Appeal's proportionality analysis did place reliance on the fulfilment of South Africa's obligations under international law as well as the public health objectives of the intervention. The SCA majority judgment focused primarily on the public health objectives behind the advertising ban, explicitly stating that the public health objectives underpinning the advertising ban offered a strong basis to limit individual rights.[593] Specifically, the SCA majority cited a case in the United Kingdom which also concerned the limitation of free speech for tobacco producers, and considered South Africa's obligations under international law:

> 'This approach is reflected in British American Tobacco UK Ltd & others v The Secretary of State for Health: "The protection of health is a far reaching social policy. The right to commercial free speech, while less fundamental than political or artistic free speech, is protected by the Convention and restrictions must be justified. However, it will be principally for the decision maker to resolve how best the aim can be achieved by restricting promotion of extremely harmful but historically lawful products. While the test of 'proportionality' cannot be escaped, the need for advertising restriction on tobacco products is not substantially in issue and we are dealing with a restriction on the very edge of a much wider restriction that

[591] Ibid at para 42.
[592] *BAT I* supra note 68 at para 35
[593] *BAT II* supra note 68 at para 28.

> is not challenged nor is capable of challenge." In my view this is a classic example of a case in which matters of fact and policy are intertwined. It is heavily steeped in public health considerations which are addressed by the Act and the Framework Convention, to which South Africa is a signatory. These factors make a compelling case for justification. There are therefore powerful public health considerations for a ban on the advertising and promotion of tobacco products. The Amicus reminded us during argument that South Africa also has international law obligations to ban tobacco advertising and promotion, and that this has been the practice in many other open and democratic societies.'[594]

Consequently, when determining whether constitutional rights may be limited by public health measures targeting NCD risk factors, the competing interests of public health in combination with other obligations emanating from the Bill of Rights may present a strong basis to justify such a limitation.

The concurring judgment from Farlam JA also linked the advertising ban to the protection and realisation of the right to a healthy environment as a basis to justify a limitation of the right to health:

> 'I say this because the public health considerations addressed by the Act and set out in the Framework Convention and the right to an environment that is not harmful to the health and wellbeing of all in this country, which is entrenched in s 24 of the Constitution, clearly constitute powerful reasons for upholding the limitation.'[595]

Consequently, the framing of NCD prevention measures as not solely measures that achieve the objective of public health but that protect or realise other rights such as those under section 27(1)(b) may provide a strong basis to uphold the limitation of individual rights.

It is also worth mentioning the additional distinction made by the SCA in *BAT* about the level of protection afforded to freedom of expression when the actions taken under the right result in harmful consequences, particularly when they concern commercial speech.[596]

> 'I have already indicated that any right in the Bill of Rights may be limited by a law of general application to the extent that the limitation is reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom, taking into account the relevant factors, including the nature of the right, the importance of the limitation and its nature and extent. The right to commercial speech in the context of this case is indeed important. But it is not absolute. When it is weighed up against the public health considerations that must necessarily have been considered when imposing the ban on advertising and promotion of tobacco products it must, I think, give way. The seriousness of the hazards of smoking far out weigh the interests of the smokers as a group. As was said in Canada (Attorney-General) v JTI-MacDonald Corp: "When commercial expression is used … for the purpose of inducing people to engage in harmful and addictive behaviour, its value becomes tenuous."'[597]

In this regard, the *BAT* case illustrates that this justification in terms of section 36 can be used to defend the limitation of the rights of juristic persons where these limitations seek to prevent NCDs, even where the inroads on those rights are substantial. In addition, the case illustrates

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[594] Ibid at paras 21-2.
[595] Ibid at para 40.
[596] Ibid at para 25
[597] Ibid.

how the right being limited may carry less weight and importance in the analysis of 'colliding rights' when the behaviours carried out under that right are harmful to public health. This has particular importance for producers of other unhealthy commodities and highlights how their constitutional protections may be weakened when placed in the context of the harmful effects of their products.

(b) The role of human rights in South Africa's Covid-19 jurisprudence: defining the relationship in a modern epidemic

Following the declaration of the national state of disaster and the implementation of a lockdown in March 2020, there were several cases brought against the government. Initially, many of these were either dismissed (such as the application by Hola Bon Renaissance challenging the lockdown) or settled (as in the case of doctors being forcibly quarantined in Limpopo).[598] In the early stages of the pandemic, there was thus little judicial intervention in the public health response to the COVID-19 epidemic, and some litigation that influenced policies and public health responses may not have been captured within court decisions. In the months that followed, however, the COVID-19 pandemic yielded an entirely new body of jurisprudence and case law concerning HR and public health, and owing to the rapid and continually unfolding responses to the pandemic, also led to increasingly inconsistent approaches to the relationship.

At first blush, the COVID-19 jurisprudence may not appear to be entirely relevant or instructive for an approach to the NCD epidemic given the contrasting communicable natures of the two epidemics. Yet both epidemics have common features. In Chapter 1, I discussed the potential of the NCD epidemic to cause significant disruptions to the healthcare system over the long term, which echoes the more immediate impact of the COVID-19 pandemic. Beyond this, both epidemic responses rely heavily on NPIs to prevent disease, and these interventions often limit individual rights for the protection of population level public health – something discussed in more detail in Chapter 3. For these reasons, there is significant value in drawing out the lessons that emerge from COVID-19 jurisprudence on the interaction between HR and public health, and applying these to the NCD epidemic.

Given the volume of cases considered and the differing approaches followed, this section of the analysis has been structured using the conceptual framework. It should be highlighted at the outset that the categorisation of the cases does not speak to the correctness of their outcomes or reasoning per se. Rather than assessing the correctness of these individual decisions, this Chapter rather aims to critique the approach adopted with specific regard to the relationship between HR and public health.

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[598] '"Disingenuous" Limpopo Health MEC releases forcibly quarantined doctors' *Medical Brief* 15 April 2020 available at https://www.medicalbrief.co.za/archives/disingenuous-limpopo-health-mec-releases-forcibly-quarantined-doctors/, accessed 21 November 2020; Clement Manyathela 'ConCourt Dismisses Application Seeking to Declare Lockdown Unconstitutional' *Eyewitness News* 30 March 2020 available at https://ewn.co.za/2020/03/30/concourt-dismisses-application-seeking-to-declare-sa-lockdown-unconstitutional, accessed 20 November 2020.

(i) Non-recognition of human rights

The earliest decisions on issues related to the COVID-19 pandemic adopted a decidedly non-interventionist approach in which the judiciary deferred to the government's decisions without any consideration of the HR implications of the regulations. Each case makes much of the uncertainty and novelty of the pandemic as justification for the court's non-intervention.

Decided on 27 March 2020, *Ex Parte: van Heerden*[599] was probably the first COVID-19 related judgment to emanate from the South African judiciary. Shortly after the announcement of the nation-wide lockdown, the applicant's grandfather passed away in a home fire and the applicant wished to travel inter-provincially to assist his mother with funeral arrangements. The applicant approached the High Court to be granted a limited exception to travel under the lockdown rules, but the Court dismissed the application. The Court's reasoning was terse and communicated clearly its unwillingness to evaluate or assess the government's decision to limit freedom of movement in such a radical manner, stating: 'I have extreme sympathy for the applicant but I must uphold the law. Unfortunately, presently, the law prohibits that which the applicant wants to do however urgent and deserving.'[600]

Similar levels of deference can be observed in *Gcilitshana v Director of Public Prosecutions*,[601] a case that arguably concerned an even greater infringement of rights and impacted public health negatively. The applicant had been unable to finalise his bail proceedings with hearings being delayed due to the pandemic. The case outlined in detail how COVID-19 outbreaks in the prison and quarantine requirements on the magistrate and prosecutor had left the applicant unable to obtain bail. The High Court had to determine whether 'a grave injustice could occur if there is no lawfully justifiable reason to detain an arrested person'.[602] The High Court intervened only to order the magistrate to expedite the bail proceedings, which would anyway occur within the same week of the judgment, but did not find the delay unjust, stating: 'This fact has to be viewed in the light of the fact that the outbreak was new, nobody has had an opportunity to deal with the situation before. It was a national disaster'.[603] This approach failed to engage with the HR implications of detainees being unable to access bail, or to consider the public health benefits of utilising bail to reduce overcrowding in prisons. In addition, the case appeared to exceptionalise the COVID-19 pandemic to justify adopting an approach to constitutional rights that deviated considerably from previous jurisprudence.

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[599] *Ex Parte: van Heerden* [2020] ZAMPMBHC 5.

[600] Ibid at para 16. Roelofse AJ expands somewhat on the exceptionalism of COVID-19 at paras 1-3, stating:

> 'Coronavirus disease ("COVID-19") has taken a terrible grip of the World - it is described as an invisible enemy […] The media keeps live count the numbers of those who have perished. The drive to curb the COVID-19 menace, its global health and economic effects is unprecedented. South Africa is not spared. […] Here, the death toll is expected to rise dramatically as elsewhere in the world.'

[601] *Gcilitshana v Director of Public Prosecutions* [2020] ZAECGHC 32.

[602] *Majali v S [*2011] ZAGPHC 74 at para 14.

[603] *Gcilitshana* supra note 601 at para 28.

(ii) Conflicts between public health and human rights

Despite the fact that constitutional rights were not suspended during the lockdown and yet substantial incursions of civil and political rights emanated from the COVID-19 lockdown, there were only a few cases that framed public health objectives as in conflict with rights.

The decision in *Mohamed v The President of the Republic*[604] was one of the first judgments in which the COVID-19 lockdown was at the front and centre of the issue. A group of applicants approached the Court claiming their rights to freedom of movement, freedom of religion, freedom of association and dignity were violated by the prohibition on religious gatherings. The applicants submitted that their specific understanding of their religion requires daily prayers in congregation and that the regulations presented them with a 'Hobson's Choice'. The respondent maintained that the prohibition on gatherings was 'necessary to curb the infection rate and to manage the healthcare system to prevent it from being wholly overwhelmed and collapsing'. The Court refused to craft an exemption permit for the applicants stating:

> '[T]he world over, entire countries of people have had to suffer similar inroads to their civil liberties and way of life – in this respect, South Africa is not unique or alone in its efforts. In some countries, these restrictions were placed too late and others have suffered criticism of being too draconian. What they all have in common is the presence of COVID-19 and the toll it has taken on human life in so many ways.'[605]

The Court formulated the applicants' individual exercise of their religion in opposition to the 'greater good' and held:

> '[E]very citizen is called upon to make sacrifices to their fundamental rights entrenched in the Constitution. They are called upon to do so in the name of "the greater good", the spirit of "ubuntu" and they are called upon to do so in ways that impact on their livelihoods, their way of life and their economic security and freedom. Every citizen of this country needs to play his/her part in stemming the tide of what can only be regarded as an insidious and relentless pandemic.'[606]

The Court juxtaposed the applicants' rights to freedom of religion with the rights of the public to enjoy the rights to life, access to health care, access to an environment that is not harmful to their health and wellbeing, and the right to dignity.[607]

The case of *De Beer v Minister*[608] produced a heavily criticised judgment which effectively invalidated the State of Disaster regulations wholesale, even those provisions which may have justifiably limited rights or which did not limit rights at all. The applicant in the case challenged the validity of the declaration of a national State of Disaster and the pursuant regulations. The Court held that the regulations 'go beyond the mere issue of saving lives, some of which, with the greatest degree of sensitivity, international experience has shown, may

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[604] *Mohamed v The President of the Republic* 2020 (5) SA 553 (GP).
[605] Ibid at para 76.
[606] Ibid at para 75.
[607] Ibid at para 44.
[608] *De Beer and Others v Minister of Cooperative Governance and Traditional Affairs* [2020] ZAGPPHC 184, 2020 (11) BCLR 1349 (GP).

inevitably be lost'.[609] Broadly, the Court failed to consider the implications of the regulations on rights such as the right to life and health, paying only lip service with a brief reference to these rights, and starkly framing the matter as an 'anguishing conundrum [of the] choice between "plague and famine"'.[610] Despite the Court's categorisation of these rights as conflicting, it did very little to investigate the limitation of rights by the lockdown restrictions, simply stating that 'lack of rationality would result in such a measure not constituting a permissible limitation of a Constitutional right in the context of Section 36 of the Constitution'.[611] With this in mind, the Court proceeded to apply the rationality test to certain regulations. The Court considered a series of alternative formulations to the lockdown provisions: night vigils need not be banned when social distancing between participants and a mandatory closed casket could render such practices safer; time restrictions around physical exercise were not necessary when limiting the size of groups exercising together seemed more effective; and the Court held that wholesale restrictions on visiting spaces like parks could be replaced by regulating those visits more carefully.

Not all regulations were held to be impermissible limitations. The Court stated that 'the cautionary regulations relating to education, prohibitions against evictions, initiation practices and the closures of night clubs and fitness centres, for example, as well as the closure of borders' could pass muster. Recognising that some regulations could withstand challenge, the Court limited its review to a handful of regulations and declared these to be unconstitutional and invalid in toto. Though this finding was mitigated by a suspension of invalidity and ultimately was appealed, the approach of the court reflected a prioritisation of civil and political rights to a degree that undermined the totality of the public health response to COVID-19.

In *FITA,* the applicant challenged the ban on the sale of tobacco products in response to the COVID-19 pandemic, claiming that the ban was irrational and breached the principle of legality. The Minister of Cooperative Governance and Traditional Affairs (COGTA) meanwhile argued that the ban served to promote and protect the rights to life and healthcare.[612] The Court agreed with this latter characterisation, upholding the ban on the basis that it served to protect these rights:

> 'We hold the view that a vigorous attempt to contain the spread of the virus at all costs had to be made especially bearing in mind the high COVID-19 mortality rates and the fact that, as a developing country with limited resources as well as an already overwhelmed healthcare system, South Africa is ill-equipped to survive the full brunt of the pandemic at its peak if no concerted efforts are made to contain the virus. In line with its constitutionally mandated duties to preserve life and provide adequate health care, the State was under a duty to adopt

[609] Ibid at para 6.
[610] Ibid.
[611] Ibid.
[612] *FITA* supra note 350 at para 43 where the court stated:

> 'In our view, the medical material and other reports, inclusive from the WHO, considered by the Minister, though still developing and not conclusive regarding a higher COVID-19 virus progression amongst smokers compared to non- smokers, provided the Minister with a firm rational basis to promulgate regulations 27 and 45, outlawing the sale of tobacco products and cigarettes. This in our view is a properly considered rational decision intended to assist the State in complying with its responsibilities of protecting lives and thus curbing the spread of the COVID-19 virus and preventing a strain on the country's healthcare facilities.'

> measures to ensure that the already fragile healthcare system was not overwhelmed even further.'[613]

The Court noted that it was

> 'persuaded by the Minister's submission that FITA's argument is misconceived as it ignores the context under which the regulations were promulgated. Given that an unprecedented disaster had just hit South Africa requiring swift and effective action from the State, it would be illogical to require the Minister to meet a higher threshold (that is "strictly necessary") and require her to jump through proverbial hoops when the enactment of the regulations was for a laudable purpose.'[614]

The inconsistency in framing and jurisprudential approaches was perhaps highlighted most clearly in the two judgments dealing with the tobacco ban. The *BAT III* decision found the tobacco ban unconstitutional, directly conflicting with the decision in *FITA* which upheld the constitutionality of the ban. Departing substantially from the deferent approach in *FITA*, Mlambo JP highlighted the need to weigh constitutional rights against public health imperatives: 'It can hardly be contested that the COVID-19 global pandemic resulted in a national disaster that gave rise to the need to take urgent action. This urgent action must be contextualised against the constitutional obligation to secure the well-being of the people of South Africa'.[615]

Schooling and the education of children was a particularly contentious issue, especially as evidence mounted about how COVID-19 affected children. On 1 July 2020, in *One South Africa Movement* the applicants attempted to stop the re-opening of schools.[616] They argued that re-opening schools would compromise public health and their application sought to prevent children being placed 'on the altar of economic and financial interests.'[617] They relied on the rights to life and dignity to justify their relief. With regard to the applicants' contention that the government should impose a higher level of lockdown, the Court commented that the 'measures the state adopts to deal with the threat posed to the right to life must in turn safeguard and protect other constitutional rights which are also affected by the COVID-19 crisis'.[618] The Court's approach was one which sought to balance public health objectives against other rights. In its outcome, it held that it would be permissible to adopt less stringent public health objectives to support the realisation of other rights:

> 'Thus, while the initial concern and response to the virus was largely and understandably a public health one, with time the impact of the virus on issues such as the economic survival of nations and their citizens, and the simple ability to live a meaningful and decent life, has come sharply into focus. The ability of governments, in particular those in the developing world, to respond holistically to the needs and well-being of their citizens has come under increased pressure. This has been exacerbated by the inevitable recognition over time that the virus will

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[613] Ibid at para 42.
[614] Ibid at para 85.
[615] *BAT III* supra note 349 at para 212.
[616] *One South Africa Movement* supra note 353
[617] Ibid at para 131.
[618] Ibid.

> be with us for some time and that a cure in the form of a vaccine is still somewhere in the future.'[619]

The Court also endorsed the view that 'it was possible to protect both lives and livelihoods, without choosing one over the other' in justifying less restrictive public health measures.[620] The Court's view of the relationship between public health and HR generally saw the pandemic and consequent public health measures of less urgent importance than the competing economic interests and other civil and political rights, such as:

> 'the right to reasonable access to health care services for all the population, and not only for Covid-19 patients; the right to freedom of movement; the right to dignity which attaches to the ability to earn a living and feed one's family; the right to free choice of one's trade, profession and occupation; and the right to property. Moreover, the measures that the state adopts must also not hinder its ability to meet its constitutional obligations progressively to provide access to housing, social-welfare, health care and education. The health of the economy and fiscus are central to its ability to do so.'[621]

The Court clearly viewed the right to education and the right to food to stand in conflict with the right to health and the right to life, and accordingly approached the section 36 limitation test accordingly:

> '[I]n our view it must follow that in the balancing exercise between the competing rights, the balance was appropriately struck between the right to life and other implicated rights, such as the right to education, and the right to food.' [622]

This approach is to be contrasted with the *Equal Education* case as discussed below, where the rights to health, food and education are aligned.

In *Esau*, the Court had to decide on the constitutionality of the State of Disaster regulations on level four.[623] Specifically, the Court had to consider whether limitations on the rights to dignity, freedom of movement and trade could justifiably be limited to prevent COVID-19. The Minister argued that the COVID-19 regulations worked to promote the rights to life, freedom and security of person and access to healthcare system – not of a particular person but of broader South African society.[624] The Supreme Court of Appeal accepted the argument that the NPIs served to protect societal rights, specifically the right to life:

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[619] Ibid at para 2.
[620] Ibid at para 98.
[621] Ibid at para 90.
[622] Ibid at para 165.
[623] *Esau* supra note 343.
[624] Ibid at para 121 which reads:

> 'The COGTA Minister's starting point in justifying the regulations under attack was that the State was under an obligation to respect, protect, promote and fulfil the fundamental rights of everyone to life, to freedom and security of the person and to access to health care services. These rights were threatened by the pandemic. In order to arrest the spread of Covid-19, it was necessary to compel people to remain at home. The logic is clear:
>
> > "Uninfected persons who stay at home minimize their contact with infected persons and infected surfaces. Infected persons who stay at home reduce the occasions upon which they may infect others or public surfaces."'

> 'At its most basic, the purpose of the limitation of the fundamental right to freedom of movement and of trade, occupation and profession was the protection of the health and lives of the entire populace in the face of a pandemic that has cost thousands of lives and has infected hundreds of thousands of people. In a sense, there has been something akin to a trade-off: the rights to freedom of movement, to dignity and to pursue a livelihood were limited to prevent the spread of Covid-19 and that, in turn, protected the right to life of many thousands of people, who would have died had the disease had the opportunity to run unchecked through the country.'[625]

This recognition also placed public health objectives at odds with other fundamental rights, however, and framed the goals of public health as diametrically opposed to the protection of other civil and political rights, with the realisation of one characterised as mutually exclusive to the realisation of the other:

> 'At the same time, an easing of those strict restrictions was envisaged as and when appropriate. But that easing came at a cost. Even though the COGTA Minister described level 4 as being "largely a success", she said that it 'resulted in the increased spread of the virus, albeit within acceptable parameters'. By way of example, she said that an increase in the doubling rate of the disease was noted, from 15 days under level 5 to 12 days under level 4. By ameliorating the harshness of the lockdown and moving to level 4, the COGTA Minister sought to strike a balance "between saving lives and saving livelihoods". For the most part, I am satisfied that the means chosen – and the limitation of rights that those choices brought about – were objectively rational. They were also proportional in the sense that, in the circumstances, those means were necessary to deal with the exigencies faced by the country, struck appropriate balances between the adverse and beneficial effects of the response to the pandemic and were suitable for their intended purpose.'[626]

In *Democratic Alliance*,[627] the Court had to consider the constitutionality of the Disaster Management Act and whether there was sufficient parliamentary oversight of the COGTA powers exercised under the COVID-19 pandemic. In this case the Court specifically acknowledged the need to ensure the protection of rights within the Bill of Rights, even during a pandemic, and that limitations of these rights ought to be justified in terms of section 36 of the Constitution:

> 'We must not lose sight of the fact that rights enshrined in the Bill of Rights must be protected and may not be unjustifiably infringed. It is for the legislature to ensure that, when necessary, guidance is provided as to when limitation of rights will be justifiable. It is therefore not ordinarily sufficient for the legislature merely to say that discretionary powers that may be exercised in a manner that could limit rights should be read in a manner consistent with the Constitution in the light of the constitutional obligations placed on such officials to respect the Constitution. Such an approach would often not promote the spirit, purport and objects of the Bill of Rights. Guidance will often be required to ensure that the Constitution takes root in the daily practice of governance. Where necessary, such guidance must be given. Guidance could

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[625] Ibid at para 132.
[626] Ibid at para 142.
[627] *Democratic Alliance v Minister of Co-operative Governance and Traditional Affairs and Others* [2021] ZAGPPHC 168.

> be provided either in the legislation itself, or where appropriate by a legislative requirement that delegated legislation be properly enacted by a competent authority.'[628]

(iii)Public Health and Human Rights and Complementary

Despite the initial approach of the judiciary in exercising a high level of deference to the government's response to the COVID-19 pandemic, the courts did begin to hand down judgments that knitted together HR with public health.

One of the most significant judgments concerning the COVID-19 response was *Khosa,*[629] which marked a significant turning point in the judiciary's willingness to scrutinise state responses to the pandemic. The applicants essentially sought for the Court, inter alia, to restate the entitlement of all persons to enjoy rights in the context of the State of Disaster. The *Khosa* case was centrally about incidents of torture and brutality perpetrated by members of the South African security forces against citizens in the course of the state's response to COVID-19.[630] The Court ordered the creation of a mechanism for citizens to report allegations of torture or cruel, inhuman or degrading treatment or punishment committed during the State of Disaster. Specifically to Mr Khosa, the judgment ordered investigations to be completed and provided to the Court. The *Khosa* judgment outlines the tension between HR and public health objectives that is the centre point of South Africa's COVID-19 response succinctly:

> 'I must emphasize that all counsel were in agreement that a lock-down was necessary, and I must add that I am of the same view less there be any doubt about that. The public is however entitled to be treated with dignity and respect whether rich or poor. Section 7 of the Bill of Rights makes this abundantly clear and there is no doubt about that.'[631]

It is also worth noting, however, that the precise dichotomy between rights and public health objectives that is exposed in *Khosa* is distinct from many other instances of conflict between HR and public health. The brutality at the centre of the Khosa case served no public health goal and could be categorised uncontroversially as an abuse of power. Fabricius J recognised the importance of protecting HR in the context of the pandemic response, stating:

> '[I]f the Government is held to these Constitutional obligations and the citizens trust is restored, and lawful rational Regulations are obeyed, the expected flood of litigation will retreat and the spread of the virus will be contained until the appropriate vaccine is found. The fact of the matter is thus simply the following: Communality or failure.'[632]

There were other cases that attempted to adopt a complementary approach to public health and HR, specifically focusing on whether different groups of people could be excluded from accessing COVID-19 social safety nets. The broader objective of addressing poverty and historical inequities highlighted in *TAC* was reiterated in the *Solidarity* case.[633] Here, the

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[628] Ibid at para 75.

[629] *Khosa and Others v Minister of Defence and Military Defence and Military Veterans and Others* [2020] ZAGPPHC 147, 2020 (5) SA 490 (GP).

[630] Ibid at para 24.

[631] Ibid at para 19.

[632] Ibid at para 9.

[633] *Solidarity obo Members v Minister of Small Business Development and Others; Afriforum v Minister of Tourism and Other*s [2020] ZAGPPHC 519.

applicants sought an order to review and set aside a decision by the Minister of Tourism to introduce race-based criteria to the provision of COVID-19 emergency assistance. The Court commented that pursuing equality goals should not be seen as contrary to effectively providing a COVID-19 response, but that it is important to understand that COVID-19 impacts the poor and disadvantaged to the greatest extent. The government's attempt to calibrate its response to factor in historical disadvantage was held to be 'not only permissible at the level of principle but warranted and necessary'.[634] The Court also heeded that 'in a time of crisis when people are at their most vulnerable context matters perhaps even more so than in a time of normality and the policy response must factor that in to its dynamics'. In addition, poorer individuals were more affected by the lockdown and suspension of economic activity than those in the middle and upper class who were in a position to work remotely. In this sense, the judgment's prioritisation of historically disadvantaged groups supported efforts that worked to assist the groups most affected by the pandemic.

The case of *Scalabrini Centre of Cape Town*[635] concerned itself with whether asylum seekers and permit holders could be lawfully excluded from receiving the COVID-19 distress grant. The Court considered that these persons were 'locked-in' by the pandemic and that the lockdown impacted their ability to secure food and basic necessities. The Court found that a person's immigration status is an irrational an unreasonable ground for exclusion, and further that the interrelatedness of their rights to equality, dignity and access to social assistance cannot be overemphasised. It insisted that '[w]hilst it cannot be disputed that the COVID-19 pandemic must be fought by all means necessary, it must be constantly borne in mind that the Constitution and the Bill of Rights in particular, ought to be the touchstone against which the formulation and implementation of regulations is measured'.[636]

The complementary approach can also be observed in the case of *South African Human Rights Commission*,[637] which concerned the right to housing and the suspension of evictions during COVID-19. The Human Rights Commission was able to successfully interdict the City of Cape Town from evicting persons or demolishing informal housing structures. The Court condemned the City's conduct as 'inhumane, heartless and done with scant regard to safety, security and health particularly in the light of the COVID-19 pandemic',[638] and, importantly, recognised that vulnerability is exacerbated during the pandemic.[639] The Court reiterated that the purpose of judicial oversight over evictions and the demolition of homes is intended to protect the right to dignity, housing, safety and security of the person and life – rights which are interrelated.[640]

In *CD,*[641] the applicants approached the Court for an order to enable them to travel from Cape Town to Bloemfontein and back to fetch their children (aged 7 and 10), who were staying

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[634] Ibid at para 36.
[635] *Scalabrini Centre of Cape Town v Minister of Social Development* [2020] ZAGPPHC 308; 2021 (1) 553 (GP).
[636] Ibid at para 41.
[637] *South African Human Rights Commission and Others v City of Cape Town and Others* [2020] ZAWCHC 84, 2021 (2) SA 565 (WCC).
[638] Ibid at para 16.
[639] Ibid at para 58.
[640] Ibid at para 47.
[641] *C D and Another v Department of Social Development* [2020] ZAWCHC 25.

with their grandparents. The Court took an approach which considered the best interests of the children, their well-being and their physical health during the pandemic:

> 'The well-being and physical health of the children in these turbulent times are being placed at risk. The situation is clearly an urgent and troubling one, and the issues raised by the Respondent pertaining to the failure to move the children before the lockdown or the fact that the application was brought on 6 April, does not detract from the urgency. The best interests of the children would undoubtedly be served if permission were to be granted for them to be fetched to travel from Bloemfontein to Cape Town.'[642]

In *Equal Education,* the suspension of the National Schools Nutrition Programme (NSNP) during lockdown was challenged. The Court went to great lengths to explain the interrelationship and interdependence of the rights to education, nutrition and health.[643] The Court noted that in government policies on the NSNP, the link between the rights to education, health and food are made clear. The programme was established with the express purpose of 'contribut[ing] to the improvement of education quality by enhancing … learning capacity, school attendance and punctuality… [and] general health development by alleviating hunger'.[644] The Court also highlighted the role of food insecurity and hunger in contributing to adverse health conditions, including obesity and micronutrient deficiencies – problems which the NSNP assisted in ameliorating.[645] The Court went on to find that the NSNP formed part of the state's constitutional obligations under the children's right to basic nutrition.[646]

(c) The approach of COVID-19 jurisprudence

The above cases illustrate highly variable and at times inconsistent jurisprudence on COVID-19. More interestingly, despite decades of rich development in the relationship between public health and HR, as well as South Africa's own section 36 jurisprudence, one can see the historical phases of this history woven throughout these cases, as though the jurisprudence began afresh in the pandemic.

This conundrum was perhaps best expressed by the Supreme Court of Appeal in *Esau*. After asking 'what is the role of the courts in circumstances such as these?', the Court answered powerfully: 'in times of national disaster… "the laws are not silent" … "they speak the same language in war as in peace"'.[647] Continuing, the Court referred to the 1879 case in *Willem Kok and Nathaniel Balie,* where the Court noted 'that even in times of upheaval, the courts' "first and most sacred duty is to administer justice to those who seek it"'[648]. This judgment,

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[642] Ibid at para 13.
[643] *Equal Education* supra note 447 at paras 34-41.
[644] Ibid at para 36 referring to White paper on Reconstruction and Development 1994.
[645] Ibid at para 30 which reads:

> 'The severity of high levels of unemployment leads to poverty and consequently to food insecurity. Even when employed, the income is not adequate with the informal sector employment totalling 5 million, who in turn supports 16 million people. The parents can accordingly not provide sufficient food and nutrition to their children. Children who suffer from hunger are at risk of various forms of malnutrition which include wasting, stunting, obesity and micronutrient deficiencies.'

[646] Ibid at para 42.
[647] *Esau* supra note 343 at para 4.
[648] Ibid.

laden with jurisprudence dating back 140 years prior to the COVID-19 pandemic, resoundingly and definitively emphasised that the duty of the Courts in times of crisis, remains as the duty is in times of normality.

Against this backdrop, cases which adopted a non-interventionist approach were divorced from the chain of jurisprudence that underpins our legal system. These cases, subsumed with the severity of the COVID-19 pandemic, witnessed courts essentially abrogating their duties to safeguard and promote the realisation of HR during the earlier phases of the pandemic. Though these cases upheld strong public health responses, they did not adequately consider the reasonableness and justifiability of the resulting HR limitations. Whilst the COVID-19 pandemic was novel, there was clear direction from previous cases such as *TAC*, which would have compelled courts to interfere where the public health response interfered with HR. Again, *Esau* offers guidance on duties the judiciary bears in a time of crisis such as COVID-19, duties of oversight and guidance to other branches of government:

> 'In other words, even in times of national crisis, as this undoubtedly is, the executive has no free hand to act as it pleases, and all of the measures it adopts in order to meet the exigencies that the nation faces must be rooted in law and comply with the Constitution. The rule of law, a founding value of our Constitution, applies in times of crisis as much as it does in more stable times.'[649]

But this duty is not unlimited: it requires a balancing between allowing the Executive the flexibility and freedom to respond to crisis while still maintaining and upholding the rule of law.[650] While a conflict framing approach to HR and public health is not the most desirable in Mann's approach, it is not an inherently flawed approach to addressing public health responses in the context of a constitutional democracy, particularly one such as ours where section 36 remains a touchstone to any limitation of rights.

Whilst the complementary approach is a desirable one, there will undoubtedly be instances where public health efforts do act to limit HR. In such instances, however, it is imperative that the courts follow an approach of balancing competing rights and justifying limitations of these rights. Of concern in the conflict phase of COVID-19 jurisprudence is that the lack of recognition of many socio-economic rights as competing rights and values to be balanced against the civil and political rights infringed by public health measures. In particular, the *De Beer* case signalled a troubling lack of regard for the competing rights to health and life against the rights to freedom of movement and autonomy discussed so extensively.

The careful balancing between public health and rights was perhaps most clearly outlined in *One South Africa,* which was one of the few cases that engaged with section 36 in detail. It offers a clear pathway to consider how best to balance rights in a pandemic situation. In fact, *One South Africa* offers a counter point to Mann's approach of reading the rights to

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[649] Ibid at para 5.
[650] Ibid at para 6 which reads 'That is not to say that the courts have untrammeled powers to interfere with the measures chosen by the executive to meet the challenge faced by the nation. Judicial power, like all public power, is subject to the rule of law. Perhaps the most obvious constraint on the power of the courts is the doctrine of the separation of powers, a principle upon which our Constitution is based and which allocates powers and responsibilities to the three arms of government – the legislature, the executive and the judiciary.'

health as complementary to other rights as, within the context of COVID-19, there were instances where socio-economic rights were competing with the rights to health and life.[651] At the outset, the Court recognised that there is no hierarchy of rights within the Bill of Rights and there can be no hierarchy applied when undertaking a section 36 analysis.

> ‘In exercising this power, the executive must obviously respect, protect, promote and fulfil all fundamental rights implicated. But even this involves a range of choices as to how best to do it. Therefore, it is not useful, and may indeed be misleading, to appeal to the logicality of a decision of this nature in challenging its constitutional validity. Instead, this Court must look to the relevant principles of law that apply. In the first place, it is well settled in our law that there is no hierarchy of rights under the Bill of Rights, and that different rights may compete against each other.’[652]

Importantly, the Court recognises that rights may not be complementary in some situations, that these competing goals must be balanced in terms of section 36, and that measures that protect other rights ought to be upheld. Even in the context of the COVID-19 pandemic, there may be other rights which require protection, although not to the exclusion of public health objectives:

> ‘In this case, the constitutional issue implicates a range of fundamental rights, which pull in different directions. The measures the state adopts to deal with the threat posed to the right to life must in turn safeguard and protect other constitutional rights which are also affected by the Covid-19 crisis. Section 7(2) expressly requires this of the state. These include, for example, the right to reasonable access to health care services for all the population, and not only for Covid-19 patients; the right to freedom of movement; the right to dignity which attaches to the ability to earn a living and feed one’s family; the right to free choice of one’s trade, profession and occupation; and the right to property. Moreover, the measures that the state adopts must also not hinder its ability to meet its constitutional obligations progressively to provide access to housing, social-welfare, health care and education. The health of the economy and fiscus are central to its ability to do so.’[653]

Despite the value of the ‘conflicting’ phase of the case law and the importance of engaging with section 36 of the Constitution, the complementary cases represent a strong approach to HR within the context of a pandemic. Framing the goals of public health as mutually reinforcing to the promotion of certain rights enabled the courts to more comprehensively weigh and balance competing interests as required by section 36. It is interesting to note that the first non-interventionist case was the *Khosa* case where, undoubtedly, the public health objectives were not compromised but rather enhanced by the protection of individual liberties and rights. The *Equal Education* case also contained a richness from its holistic reading of rights and broader public health that allowed the Court to make an order that upheld other rights and was ultimately beneficial to the health of children – a health and HR issue that was not erased but rather exacerbated by the pandemic.

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[651] *One South Africa Movement* supra note 353 at para 86-7.
[652] Ibid at para 88.
[653] Ibid at para 91.

IV. CONCLUSION: LESSONS FOR NCD PREVENTION

The discussions of various historical epidemics analysed above offer a useful prism to understand how different treatments of rights and public health may be reconciled. There is, however, a somewhat divergent approach that can be detected in the handling of COVID-19 and that of previous epidemics. In this context, it was clear that public health interests often were of paramount importance due the immediate and severe disruptions caused by the COVID-19 pandemic. However, these cases illustrate the substantial impact that the manner of framing the relationship between HR and public health may have on the limitation and incursion of rights, and the outcome of judicial challenges. Where HR were invoked in support of public health measures, the limitations imposed by those measures were more likely to be found to be constitutional. By contrast, cases that found COVID-19 measures to be unconstitutional often placed disproportionate emphasis on individual rights with little regard for the socio-economic rights that would be protected through the adoption of public health measures.

The emphasis on the immediate burden and severity of the disease or epidemic poses immense difficulties for addressing diseases such as NCDs. This is because the effect of the epidemic will only be felt later in time but to be effective, prevention measures must be adopted in the present. If the current approach to public health issues is maintained going forward, it is unlikely that NCD prevention efforts will be met with the same sense of urgency or willingness to limit individual rights as was observed in COVID-19. Consequently, there is immense value in approaching the section 36 analysis in the context of NCD measures with through a lens of complementarity as espoused by Mann. At a minimum, this lens may assist Courts to identify 'colliding rights' in assessing the justifiability of the limitation and strength arguments to find the limitations justifable. This is of particular importance given that where limitations analyses are couched solely in terms of the individual rights being limited, without regard for the rights the measure is protecting, the proportionality analysis is weakened and the measure is more likely to be found to unjustifiably limit the individual right.

Decisions such as *BAT II* and other cases related to epidemics do illustrate that the interests and objectives of public health are not insignificant in the minds of the judiciary. Even outside of emergency, pandemic contexts such as COVID-19 these aims have been used to justify the limitation of individual rights, particularly in instances where the rights being limited are those of the producers of harmful products. In these cases, the proportionality analysis was strengthened in favour of public health objectives where there was an aligning right being protected and promoted by the public health measure. However, it is important to note that the successful outcomes are not solely the result of the prioritisation of the right to health but in many instances, were buttressed by international obligations and/or strong evidence of the severity and causes of the public health problem as well as the effectiveness of the suggested intervention.

The next Chapter will investigate these aspects of the proportionality analysis – considering how they have been considered in the appplication of section 36 to NCD prevention interventions, and tobacco control, with a particular consideration of the evidentiary and other components of the analysis that arise in the context of adopting and implementing novel public health interventions which limit constitutional rights.

CHAPTER 7
CONSIDERATIONS IN JUSTIFYING THE LIMITATION OF RIGHTS IN THE CONTEXT OF NCD PREVENTION INTERVENTIONS

I. INTRODUCTION

The previous Chapter considered the relationship between various rights and public health measures through the lens of Rautenbach's concept of 'colliding rights' as a means to resolve tensions between the rights NCD prevention measures promote and those they limit. It was concluded that in the instance of colliding rights, the competing rights being promoted and protected by the intervention may provide a justification for limitations flowing from the intervention.

As outlined in Chapter 1, the law is particularly well suited to address NCDs, offering novel but effective interventions to prevent disease. However, as Patterson et al acknowledge, a HR-based approach to such interventions may function in ways that both support and hinder NCD prevention efforts, as these interventions may both promote and limit HR.[654] As a result, it is necessary to consider what rights are implicated in these interventions and, where these interventions limit rights, how such limitations should be managed.

Gostin et al outline some of the legal interventions that could be used to prevent NCDs at individual and population levels. While South Africa has implemented some of these measures, there are others that could provide a road map for the kinds of measures South Africa could adopt next. To provide context to the discussion of how constitutional rights may interact with potential NCD prevention measures, I have developed Table 5 which outlines how these interventions may implicate various constitutional rights in both positive and negative ways.

Table 5: Legal Interventions to Prevent and Control NCDs

Domain	**Goal**	**Intervention**	**Example**	**Purpose of the intervention**	**Human right implicated**
Healthy Lifestyles	Optimal Nutrition	Agricultural Production	Food and agricultural policies, economic incentives to produce healthier foods	Increases availability of healthier food	Right to sufficient food

[654] Patterson et al op cit note116 at 48.

		Food Manufacturing, processing, and distribution	Regulation of food manufacturers and retailers	Increases availability and quality of food	Right to sufficient food
		Disincentives for buying and selling unhealthy food	Fat Taxes	Increases availability of healthier food	Right to sufficient food
		Marketing unhealthy foods	Restrictions on marketing to children	Reduces acceptability of unhealthy food Limits industry's ability to communicate	Right to sufficient food Freedom of Expression
		Nutritional information disclosure and education	Providing government nutritional guidelines, improving package labelling, menu labelling	Improves consumer understanding and knowledge about food	Right to information
		Direct Regulation	Banning unhealthy ingredients (such as trans-fats)	Reduces consumption of unhealthy ingredients that cause disease	Right to healthcare
		Public-private partnership	Voluntary targets for nutritional values	-	-
Healthy places	Nutritious dietary options in neighbourhoods, schools and workplaces	Access to affordable, healthy foods	Mobile farmers markets, zoning of unhealthy fast-food restaurants	Increases availability of healthy foods	Right to food
		Healthy foods in schools, workplaces etc	Soda bans in school vending machines, nutritional audits of cafeterias, healthy food procurement policies	Reducing availability of unhealthy foods that cause disease	Right to food Right to healthcare Children's right to basic nutrition
		School / childcare curricula and programs	Body mass index surveillance, nutrition education	Improves access to healthcare systems through increased surveillance Educates children about diet and food	Right to healthcare Right to education Children's right to basic nutrition
Healthy Societies	Social Justice	Antidiscriminati on laws	Proscribing health status discrimination	Prevents discrimination against those living with NCDs	Right to equality
	Access to services	Services to support life functions of ill individuals	At home support systems	Improves access to healthcare services	Right to healthcare
		Encouraging prevention and treatment	Metabolic screening, counselling	Improves access to healthcare systems through increased surveillance and diagnosis	Right to healthcare

		Monitoring disease in the community	Surveillance through BMI reporting	Improves access to healthcare systems through increased surveillance and diagnosis	Right to healthcare

Source: Adapted from LO Gostin (2014)[655] , Global Health Law (Harvard University Press: 2014) at

The purpose of this Chapter is not to investigate in detail the constitutionality of these specific interventions – each must be assessed within their own factual context. Instead, this Chapter will consider the components of the section 36 analysis that come into play when assessing the justifiability of a limitation imposed by an NCD prevention measure. It begins by providing a brief overview of the components of section 36 more generally and the proportionality test. Thereafter, the Chapter considers how the introduction of novel public health interventions have been analysed under section 36, with a view to understanding how the various components of the limitations analysis may function in the context of NCD interventions. I will then consider the application of section 36 in the context of two cases concerning the prohibition on tobacco sales which assessed the constitutionality of the ban and reached differing conclusions. Before concluding, I will outline how the components of the flexible section 36 test may apply to NCD prevention interventions.

II. OVERVIEW OF SECTION 36

No rights within the Bill of Rights are absolute. Rautenbach posits that there are two principles that govern the limitation of rights under the Constitution: rights are not absolute and may be limited; any limitation of these rights must be in terms of the Constitution.[656] As a consequence, where there arises a conflict between a public health intervention and HR that cannot be reconciled, this conflict must be resolved through a section 36 analysis. Much of what is discussed in this section is reasonably settled within South African law. This section does not seek to interrogate the underpinnings of section 36 or proportionality, but rather to briefly summarise the general position and apply these components in a general way to the limitation of rights that may arise where NCD prevention interventions are introduced.

Section 36 of the Constitution provides the criteria to be used when assessing whether the limitation of a right may be justifiable:

> '(1) The rights in the Bill of Rights may be limited only in terms of law of general application to the extent that the limitation is reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom, taking into account all relevant factors, including—
> (a) the nature of the right;
> (b) the importance of the purpose of the limitation;
> (c) the nature and extent of the limitation;
> (d) the relation between the limitation and its purpose; and
> (e) less restrictive means to achieve the purpose.
> (2) Except as provided in subsection (1) or in any other provision of the Constitution, no law may limit any right entrenched in the Bill of Rights.'

[655] Gostin op cit note 42 at 396-7
[656] Rautenbach op cit note 508 at 2248.

Though limitations must be assessed individually and within the specific parameters of a given infringement, this Chapter will deal generally with the application of section 36 in the context of public health interventions, seeking to outline how the flexible test can be applied in this context.

This Chapter specifically attempts to address the concern that NCD prevention interventions unduly limit individual rights and autonomy, and interrogates the extent to which these limitations can be justified. In the previous Chapter, I discussed how the assumptions regarding paternalism had created a false dichotomy between NCD prevention efforts and individual rights, while acknowledging that there may be certain instances where these efforts do infringe individual rights. For this reason, I proceed from the assumption that the public health intervention subject to the limitations analysis has been found to infringe a particular right, without reiterating the points raised about the underlying assumptions about paternalism. This assumption speaks also to the first factor under section 36, namely, the nature of the right infringed which is determined as part of the question of whether a right has been limited.[657]

Once an infringement has been established and it is confirmed that this infringement has occurred through a law of general application, the question arises as to whether the infringement is justifiable according to the criteria in section 36. In *S v Makwanyane*, the Constitutional Court outlined an approach to this analysis based on the then-section 33 of the Interim Constitution which centred on proportionality, stating:

> 'The limitation of constitutional rights for a purpose that is reasonable and necessary in a democratic society involves the weighing up of competing values, and ultimately an assessment based on proportionality. This is implicit in the provisions of section 33(1). The fact that different rights have different implications for democracy, and in the case of our Constitution, for "an open and democratic society based on freedom and equality", means that there is no absolute standard which can be laid down for determining reasonableness and necessity. Principles can be established, but the application of those principles to particular circumstances can only be done on a case by case basis. This is inherent in the requirement of proportionality, which calls for the balancing of different interests. In the balancing process, the relevant considerations will include the nature of the right that is limited, and its importance to an open and democratic society based on freedom and equality; the purpose for which the right is limited and the importance of that purpose to such a society; the extent of the limitation, its efficacy, and particularly where the limitation has to be necessary, whether the desired ends could reasonably be achieved through other means less damaging to the right in question.'[658]

Rautenbach highlights how the flexibility of this approach and the multiplicity of factors considered in this test may yield differing outcomes based on changing facts.[659] The factors enunciated in section 36 are intended to inform the factors assessed in the proportionality analysis.[660] It is also recognised, in this flexibility test, that the 'strictness' with which these factors are applied may vary from case to case.[661] The Constitutional Court has

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[657] Ibid at 2254.
[658] *S v Makwanyane and Another* [1995] ZACC 3; 1995 (6) BCLR 665; 1995 (3) SA 391.
[659] Rautenbach op cit note 508 at 2247
[660] Ibid at 2249.
[661] Ibid.

similarly underscored that the more substantial the incursion on fundamental rights by a particular action, the more persuasive the justification needed to satisfy the section 36 test.[662]

With regard to the importance of the purpose of the limitation, Rautenbach also suggests that the nature of the actor whose rights are being limited, specifically where they are a juristic person, may influence how strictly the standard is applied.[663] Also relevant to the importance of the limitation is whether the act is intra vires, and whether the actor limiting the right has the legal authority to do so. In this regard, it is important that whatever measures are adopted fall within the ambit of the powers afforded to the decision-maker.[664] The nature and extent of the limitation of the right, along with the methods used, are weighed in assessing how intrusive the limitation is on the interests protected by the right being limited.[665] Both of these factors have particular relevance in the context of the delegated authority, which is frequently used by the Minister of Health to introduce NCD prevention measures through regulations. This ought to be determined through the assessment of each measure relative to the ambit of the delegated authority and discretion.

The relation between the limitation and its purpose is concerned with whether such limitation can make a contribution to achieving the purpose, and the extent of this contribution.[666] The test is deferent to the government to a certain degree, considering only whether there is a rational relationship between the limitation and its purpose.[667] However, the application of the test and the level of deference is also dependant on the decision-maker involved in the process and the discretionary powers afforded to them, as highlighted in *Democratic Alliance:*

> 'We must not lose sight of the fact that rights enshrined in the Bill of Rights must be protected and may not be unjustifiably infringed. It is for the legislature to ensure that, when necessary, guidance is provided as to when limitation of rights will be justifiable. It is therefore not ordinarily sufficient for the legislature merely to say that discretionary powers that may be exercised in a manner that could limit rights should be read in a manner consistent with the Constitution in the light of the constitutional obligations placed on such officials to respect the Constitution. Such an approach would often not promote the spirit, purport and objects of the Bill of Rights. Guidance will often be required to ensure that the Constitution takes root in the daily practice of governance. Where necessary, such guidance must be given. Guidance could be provided either in the legislation itself, or where appropriate by a legislative requirement that delegated legislation be properly enacted by a competent authority.'[668]

In the context of public health measures, evidence will often be assessed to prove the link between the limitation and its purpose. In addition, there is a close relationship between the relation factor and the leass restrictive means factor. The least restrictive means factor stipulates that where there are multiple suitable ways to achieve the purpose of the limitation,

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[662] *S v Bhulwana; S v Gwadiso* 1996 1 SA 388 (CC) at para 18.
[663] Rautenbach op cit note 508 at 2255.
[664] Ibid at 2256.
[665] Ibid at 2255.
[666] Ibid at 2256.
[667] Ibid at 2256–7.
[668] *Democratic Alliance* supra note 627 at para 75.

the option which interferes the least with rights ought to be chosen.[669] However, this assessment only considers alternatives that are as effective in achieving the purpose as the selected measure.[670] Thus, the evidence of the effectiveness of the intervention relative to other interventions, as well as to achieving the stated purpose, is pertinent to these two legs of the proportionality analysis. In the context of public health interventions, this evidence can often be highly complex and technical, relying on expert evidence in a developing data landscape.

In the context of applying section 36 to public health interventions, certain components of the test are influenced significantly by the evidence base attached to the intervention. In particular, the relation between the limitation and its purpose, and whether the intervention is the least restrictive means to achieve the purpose, are heavily dependent on whether there is scientific evidence or a strong evidentiary base to both support the adoption of the measure and outline the potential impact the intervention may have on disease prevention.

In determining whether an intervention passes the least restrictive means test may, for instance, be dependent on demonstrating that the selected intervention is the only effective option or that alternative options are comparatively less effective at achieving the particular purpose.[671] Similarly, evidence of the effectiveness of an intervention will often need to demonstrate that there is a relationship between the purpose and the proposed intervention itself, particularly where the interventions are seated outside the healthcare system or targeting contributors to the disease as opposed to the disease itself (which will often be the case for NCD prevention interventions). Consequently, the effectiveness of the intervention relative to other interventions, as well as to achieving the stated purpose, will be relevant to making a determination on these two legs of the proportionality analysis.

This effectiveness will often turn on the evidence (scientific and expert) presented to prove the effectiveness of an intervention and thus determine whether the incursions on rights resulting from the intervention are proportionate. Rautenbach highlights this issue of evidence and indicates that the onus may assist in resolving this issue.[672] Rautenbach's view on this may be summarised as follows: '[t]he more serious an interference with a principle [a right affected or the interest or right protected by the limitation] is, the more certain must be those premises that justify the classification of intensity of interference [if the right has not been limited]'. [673] This poses some challenges in the context of novel NCD prevention efforts, where the evidence base is still developing or where consensus has not yet been reached.

The centrality of evidence in assessing the effectiveness of an intervention in a section 36 analysis was highlighted in the SCA decision in *BAT II*. Here, the SCA referred to *Minister of Home Affairs v NICRO*,[674] where the Constitutional Court highlighted that in some instances legislative choice may be based on policy and value judgments, while in other instances there

[669] Rautenbach op cit note 508 at 2257.
[670] Ibid.
[671] Ibid.
[672] Ibid at 2258.
[673] Ibid.
[674] *Minister of Home Affairs v National Institute for Crime Prevention and the Re-Integration of Offenders (NICRO) and Others* [2004] ZACC 10; 2005 (3) SA 280 (CC); 2004 (5) BCLR 445 (CC).

may empirical evidence proving that a limitation of rights is justifiable. The decision in *BAT II* states the following in the context of a proportionality analysis of the tobacco products advertising ban:

> 'It is clear that the Minister's case for justification is not based solely on facts as in a courtroom situation, but also on strong policy considerations informed by the rampaging ill-effects of tobacco use. In assessing the question whether the Minister has discharged the onus resting on him, regard must be paid to the context in which the impugned provisions were enacted. It has been said that the limitation analysis in a case such as this calls for a different enquiry. In *Minister of Home Affairs v Nicro & others*, Chaskalson CJ put it thus: "This [meaning the limitation analysis] calls for a different enquiry to that conducted when factual disputes have to be resolved. In a justification analysis facts and policy are often intertwined. There may for instance be cases where the concerns to which the legislation is addressed are subjective and not capable of proof as objective facts. A legislative choice is not always subject to courtroom fact-finding and may be based on reasonable inferences unsupported by empirical data. When policy is in issue it may not be possible to prove that a policy directed to a particular concern will be effective. It does not necessarily follow from this, however, that the policy is not reasonable and justifiable. If the concerns are of sufficient importance, the risks associated with them sufficiently high, and there is sufficient connection between means and ends, that may be enough to justify action taken to address them."'[675]

III. CONSIDERATIONS EMANATING FROM JURISPRUDENCE

Though section 36 outlines a test, the flexibility of the test has meant that different factors are understood and weighted differently in different contexts, and assessed in light of the particular limitation being analysed. In reviewing cases concerning the adoption of public health measures and constitutional rights, however, some common considerations and principles emerge amidst this flexibility. In this section, I outline some of the considerations emerging from cases concerning public health interventions and the limitation of rights.

In reviewing these cases, five broad considerations emerge as relevant to the section 36 analysis: (a) the severity of the pandemic concerned; (b) the effectiveness of the intervention limiting rights; (c) the necessity of the intervention in preventing the epidemic; (d) the impact of the intervention on other rights; and, (e) the negative externalities of the individual conduct subject to limitation. Each of these considerations is discussed in greater detail below. It should be highlighted, however, that the way in which these factors and considerations have been assessed by the courts has varied considerably, occasionally even resulting in conflicting assessments and analysis. To illustrate this variability, the two cases concerning the ban on tobacco products are analysed in a separate section.

(a) Severity of the epidemic

The severity of the epidemic or disease being prevented by the public health intervention has often been a primary consideration in determining whether an intervention justifiably limits rights. The notion of severity informs 'the importance of the purpose of the limitation' component of the analysis, with greater severity of a disease supporting greater limitations of rights.

[675] *BAT III* supra note 349 at para 21.

The severity of a pandemic also plays a role in informing the content of positive obligations under socio-economic rights, such as the right to healthcare, and this can play a role in an assessment of whether an action is reasonable or whether the right has not been fulfilled. In *TAC* for example, the Constitutional Court emphasised the severity of the HIV/AIDS pandemic in informing the importance of the intervention and the right to healthcare implicated.[676] At the time the *TAC* case was decided, the HIV/AIDS pandemic was considered the 'greatest threat to public health in our country', even amidst the myriad of other health issues facing South Africa.[677]

Similarly, in *Goliath,* which was concerned with compelling an individual to undergo isolation and treatment for XDR-TB, the Court underscored the severity of XDR-TB and the threat it posed to public health:

> 'On the undisputed medical evidence before us it is clear that XDR-TB is a highly infectious and dangerous disease. Indeed, it has been described as 'a serious global health threat'. Prevention and deterrence, rather than treatment after the fact, is therefore of prime importance.'[678]

The Court weighed the severity of the public health threat posed by XDR-TB, and particularly the difficulty in treating the disease, very heavily in justifying the compelled isolation of the applicants.

The severity of the COVID-19 pandemic was repeatedly underscored in a number of cases. The Court in *FITA* expressly stated that the severity of the pandemic, coupled with the need for urgent action, could warrant a more deferential approach and justified the Court's decision not to apply as strict a threshold on the state to justify its actions. Specifically, the Court stated:

> 'Given that an unprecedented disaster had just hit South Africa requiring swift and effective action from the State, it would be illogical to require the Minister to meet a higher threshold (that is "strictly necessary") and require her to jump through proverbial hoops when the enactment of the regulations was for a laudable purpose and was, in the literal sense, a matter of life and death. Such a view would in turn undermine the Minister's attempts at meeting her constitutionally mandated duties of promoting and protecting the right to life and the right to access to healthcare. In our view the necessity requirement is met once it is shown that there is a rational connection between the ban on tobacco sales and curbing the scourge of the COVID-19 virus in an attempt to prevent a strain on the country's healthcare facilities, a finding which we have already made.'[679]

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[676] *TAC* supra note 302 at para 1. In this regard, the Constitutional Court said

> 'The HIV/AIDS pandemic in South Africa has been described as "an incomprehensible calamity" and "the most important challenge facing South Africa since the birth of our new democracy" and government's fight against "this scourge" as "a top priority". It "has claimed millions of lives, inflicting pain and grief, causing fear and uncertainty, and threatening the economy"'

[677] *TAC* supra note 302 at para 93.

[678] *Goliath* supra note 309 at para 24.

[679] *FITA* supra note 350 at para 85.

In the later stages of the pandemic, however, the public health impact of the pandemic was weighed against the economic impact of the pandemic response, often justifying a less stringent public health response in favour of lessening the economic burden of COVID-19. In *One South Africa Movement*, for instance, the Court upheld the government's decision to move to a less stringent lockdown level by placing greater weight on the economic benefit of lessening the public health response:

> 'Thus, while the initial concern and response to the virus was largely and understandably a public health one, with time the impact of the virus on issues such as the economic survival of nations and their citizens, and the simple ability to live a meaningful and decent life, has come sharply into focus. The ability of governments, in particular those in the developing world, to respond holistically to the needs and well-being of their citizens has come under increased pressure. This has been exacerbated by the inevitable recognition over time that the virus will be with us for some time and that a cure in the form of a vaccine is still somewhere in the future.'[680]

Consequently, while the question of severity is an important factor, it does not in and of itself constitute the end of the inquiry. Often, in emphasising the severity of a pandemic, a Court will indicate its willingness to justify limitations and be more inclined to accept significant incursions on HR.

(b) Effectiveness and the evidence base supporting the intervention

The effectiveness of a given intervention has often been a point of contention amongst parties, and there have often been factual disputes about the effectiveness and safety of interventions which require determination from the Court. The effectiveness of a given intervention and the evidence available to support its adoption have frequently spoken to two components of the section 36 test: the relation between the limitation and its purpose; whether the given intervention is the least restrictive means to achieve the purpose of the limitation. Often the party introducing the intervention not only has to demonstrate that the intervention is effective in achieving its purpose, but also that it is particularly effective compared to alternative interventions.

There are many ways in which the effectiveness and safety of drugs or other interventions have been determined. In many instances, recognition and approval from the WHO has counted considerably in determining whether an intervention should be upheld or implemented. An additional point of evidence regarding the effectiveness of an intervention is whether it has received regulatory approval from South African Health Products Regulatory Authority (SAHPRA).

In the *TAC* decision, for example, there was debate as to whether nevirapine was effective and, in addition, whether it could be effective if not implemented as part of a suite of measures including counselling and formula feeding. The Court quickly disposed of the question of whether the drug was effective through reliance on the approval of the drug by the Medicines Control Council (the precursor to SAHPRA)[681] and the WHO's recommendation to

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[680] *One South Africa Movement* supra note 353 at para 2.
[681] *TAC* supra note 302 at para 61 where the Court stated:

use the drug to prevent mother-to-child transmission.[682] The issue of the comprehensiveness of the programme faced greater scrutiny, however. In this regard, the Court disagreed with the arguments advanced by the Department of Health, with the support of Dr Ntsaluba as an expert. Instead, the Court relied on the 'wealth of scientific evidence produced by both sides' which confirmed the efficacy of Nevirapine, adopting an approach backed by scientific consensus.[683] A similar approach of reliance on scientific consensus was adopted with regard to the safety concerns about Nevirapine, with the Court finding that, 'according to the current medical consensus, there is no reason to fear any harm from this particular administration of Nevirapine'.[684]

By contrast, the Court in *Goliath* opted to follow a more stringent approach than recommended by the WHO, permitting compulsory isolation over the WHO's recommendation of voluntary isolation since the voluntary isolation had been ineffective. In this regard, the Court referred to an article on the HR implications of compelled isolation for the treatment of XDR-TB, finding the resulting limitation on HR to be justifiable:

> 'The emergence of XDR-TB indicates that the WHO strategy of allowing the patient to assume responsibility for mixing with the general public may be too permissive and more attention to strategies of infection control in the community is required. In general, from both an ethical and legal perspective, measures that rely on voluntary cooperation and are the least restrictive in terms of interfering with human rights are preferred. However, if such measures prove to be ineffective, then more restrictive measures may need to be contemplated. …The use of involuntary detention may legitimately be countenanced as a means to assure isolation and prevent infected individuals possibly spreading infection to others. However, South African officials have raised human rights concerns in dealing with the country's XDR-TB and MDR-TB outbreaks, although they have conceded that forcible treatment may be a viable option in tackling the outbreak. Health workers and human rights advocates in South Africa and elsewhere must be reminded that although a country's Bill of Rights may bestow a range of human rights on individuals, these rights can usually be restricted if doing so is reasonable and justifiable.'[685]

An additional factor in determining whether the intervention was warranted and the limitation of rights justified was the question of whether other jurisdictions had adopted similar measures, and, specifically, how these jurisdictions had dealt with the limitation of rights that flowed

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> 'There is also cogent South African endorsement of the safety of nevirapine in general and specifically for the prevention of mother-to-child transmission. As indicated earlier, the Medicines Control Council registered nevirapine in 1998 (affirming its quality, safety and efficacy) and later expressly approved its administration to mother and infant at the time of birth in order to combat HIV. Although it recommends that if this is done the infant should be bottle-fed and not breastfed, that is to enhance the efficacy of nevirapine and not because it is considered to be dangerous.'

[682] Ibid at para 12 where the Court stated:

> 'In January 2001 the World Health Organization recommended the administration of the drug to mother and infant at the time of birth in order to combat HIV and between November 2000 and April 2001 the Medicines Control Council settled the wording of the package insert dealing with such use. The insert was formally approved by the Council in April 2001 and the parties treated that as the date of approval of the drug for the prevention of mother-to-child transmission of HIV'

[683] Ibid at para 58

[684] Ibid at para 60.

[685] *Goliath* supra note 309 at para 37.

from the intervention. In *Goliath*, the Court also considered the fact that other countries, specifically other democracies, had adopted a policy of compelled isolation and found it to align with HR, stating:

> 'This coupling of scientific evidence with the implications for equality indicate that where there is a greater protection and promotion of rights being served by the intervention, a lower evidentiary threshold is applied.
>
> > "It is undisputed that the compulsory isolation of the respondents at the facility amounts to a deprivation of freedom. The first question for decision is whether such deprivation is "arbitrary" or "without just cause". In my view, the answer must clearly be no: isolation of patients with infectious diseases is universally recognised in open and democratic societies as a measure that is justifiable in the protection and preservation of the health of citizens, even though it necessarily involves some intrusion upon the individual liberty of the patients concerned."'[686]

The lack of information and shifting evidence on the COVID-19 pandemic response posed significant challenges in adjudicating the limitation of rights emanating from the pandemic response. The Court in *One South Africa Movement* acknowledged the difficulties in assessing the lockdown response amidst evolving knowledge and the results of the various approaches taken by different countries in response to the pandemic:

> 'Knowledge about the virus has developed incrementally and conclusions and assumptions previously made about it have been in an ongoing state of flux. Strategies to deal with the dangers it poses have varied and been adapted over time as the knowledge base about the virus deepens and as new research unfolds new realities. That being the case, there has been no universal response to how to deal with the virus, save for agreement on measures such as social distancing, the wearing of face masks and the washing of hands. Beyond that, some countries have opted for what has become known as a hard lockdown while others have opted for a soft lockdown. In some instances, economic and social restrictions have acquired the force of law and attract criminal sanctions while in other instances guidelines are issued and it is left to the wisdom and goodwill of citizens as to how to comply with them. What this simply demonstrates is that in dealing with a virus, whose scope and dimensions are not fully known, intervention measures are not universal.'[687]

The degree to which the evidence is interrogated and the determination of whether Court's are deferent to the decision-maker varies considerably from case to case. Even where the evidence is identical, a court may apply differing evidentiary tests or question the evidence relied upon to differing degrees. This is most clearly illustrated in the context of the two decisions on the tobacco ban which are discussed in more detail in the next section.

(c) Necessity of the intervention

In determining whether the limitation imposed by a public health intervention is reasonable and justifiable, the necessity of introducing the intervention is a further significant factor.

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[686] Ibid at para 37.
[687] *One South Africa Movement* supra note 353 at paras 3-5.

Specifically, in the context of public health interventions, this component of necessity concerns the extent to which the intervention is needed to control the epidemic or disease concerned. This factor does not speak directly to one of the factors outlined in section 36, but can be weighed in determining the importance of the limitation, the relation between the limitation and its purpose, as well as informing whether other rights are promoted or protected through the limitation.

In *Goliath*, the necessity of the intervention was emphasised in the determination of whether a less restrictive means was available. The Court specifically sought to determine whether voluntary isolation could be an effective means to achieve the same purpose as the mandatory isolation. In this regard, the Court underscored the need to isolate as a means to control the pandemic, stating:

> 'XDR-TB patients have a much reduced chance for cure and a very high risk of premature death; therefore, management of these cases should be prioritised using the same basic principles as those for MDR-TB [Multidrug-resistant Tuberculosis]. XDR-TB patients *must* be hospitalized, preferably at the MDR-TB referral centres, where additional infection control measures such as isolation facilities should be provided.'[688]

Similarly, in COVID-19 jurisprudence, the limitation of rights that resulted from the adoption of public health interventions was characterised as a necessary feature of meeting the need to control the pandemic. In *Mohammed*, the Court specifically highlighted the need for citizens to accept limitations on their rights due to the necessity of controlling the pandemic:

> '[E]very citizen is called upon to make sacrifices to their fundamental rights entrenched in the Constitution. They are called upon to do so in the name of "the greater good", the spirit of "ubuntu" and they are called upon to do so in ways that impact on their livelihoods, their way of life and their economic security and freedom. Every citizen of this country needs to play his/her part in stemming the tide of what can only be regarded as an insidious and relentless pandemic.'[689]

The opposite is also true in that where the relevant interventions and controls for an epidemic are not a necessity, or where the necessity has lessened to some extent, the courts may be less willing to accept significant incursions on HR. This was illustrated in the SCA's decision in *Esau* where, in the context of the easing of the lockdown restrictions, the stringency of the initial lockdown was proportional relative to the need to control the pandemic at that time. Once the need for a hard lockdown had lessened, the Court found that the less stringent public health measures were similarly proportionate:

> '[A]n easing of those strict restrictions was envisaged as and when appropriate. But that easing came at a cost. Even though the COGTA Minister described level 4 as being "largely a success", she said that it "resulted in the increased spread of the virus, albeit within acceptable parameters". By way of example, she said that an increase in the doubling rate of the disease was noted, from 15 days under level 5 to 12 days under level 4. By ameliorating the harshness of the lockdown and moving to level 4, the COGTA Minister sought to strike a balance "between saving lives and saving livelihoods". For the most part, I am satisfied that the means

[688] *Goliath* supra note 309 at para 29. Emphasis added.
[689] *Mohammed* supra note 604 at para 75.

> chosen – and the limitation of rights that those choices brought about – were objectively rational. They were also proportional in the sense that, in the circumstances, those means were necessary to deal with the exigencies faced by the country, struck appropriate balances between the adverse and beneficial effects of the response to the pandemic and were suitable for their intended purpose.'[690]

(d) Impact on other rights

Chapter 6 considered the ways in which competing and colliding rights are assessed. There is no need to repeat this discussion here, save to note briefly that where the limitation serves to protect and promote other rights, the limitation is justifiable. That the public health response to the COVID-19 pandemic could serve a dual purpose of achieving public health goals and protecting individual rights as a basis for justifying serious incursions on individual liberties was summarised in *Esau* as follows:

> 'The purposes of reg 16 and reg 28 was to keep the pandemic under control and to save lives, while at the same time allowing more social and economic activity than hitherto. … At its most basic, the purpose of the limitation of the fundamental right to freedom of movement and of trade, occupation and profession was the protection of the health and lives of the entire populace in the face of a pandemic that has cost thousands of lives and has infected hundreds of thousands of people. In a sense, there has been something akin to a trade-off: the rights to freedom of movement, to dignity and to pursue a livelihood were limited to prevent the spread of Covid-19 and that, in turn, protected the right to life of many thousands of people, who would have died had the disease had the opportunity to run unchecked through the country.'[691]

In addition, where the limitation further infringes other rights and exacerbates pre-existing inequalities and vulnerabilities, this will weigh against the justification of limiting rights. In *TAC,* the Court emphasised the inequality in access that existed as a result of the government's inability to expand the roll out of the programme, contrasting how women using the private healthcare system had ready access to nevirapine while women in the public sector were left largely without access.[692] In this regard, the Court stated:

> 'In dealing with these questions it must be kept in mind that this case concerns particularly those who cannot afford to pay for medical services. To the extent that government limits the supply of nevirapine to its research sites, it is the poor outside the catchment areas of these sites who will suffer. There is a difference in the positions of those who can afford to pay for services and those who cannot. State policy must take account of these differences.'[693]

(e) The negative externalities of individual conduct

A factor that emerges particularly in the context of communicable diseases which can spread and infect others concerns the negative externalities that emanate from individual conduct targeted by the public health intervention. In epidemic control, many of the public health interventions restrict and control individual behaviours to reduce the risk of the disease

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[690] *Esau* supra note 343 at para 142.
[691] Ibid at para 131.
[692] *TAC* supra note 302 at para 48.
[693] Ibid at para 70.

spreading. In assessing the limitation of rights, where the individual behaviour being regulated or targeted by the limitation would prevent harm to others, the courts have been more inclined to find the limitation justifiable.

In *Goliath*, the potential public health risks posed by the individuals with XDR-TB was used to justify a mandatory isolation order that significantly curtailed their rights. In this regard, the court held:

> 'It is common cause that the respondents have been diagnosed with XDR-TB and are presently infectious. Furthermore, it appears to be beyond dispute that the respondents' contact with their families and other members of the public creates a severe public health risk of infecting others with XDR-TB. In these circum-stances, the MEC feels justified in seeking an order permitting their continued isolation at the facility until they are no longer infectious.'[694]

This need to control the negative externalities of individual behaviour as a means of controlling an epidemic was succinctly outlined in the expert evidence presented in *Esau:*

> 'Faced with the reality of the global spread of [COVID-19], governments have been forced to decide how best to intervene to mitigate the effect of the pandemic on their nation. In addition to providing the public with reliable information and advice on infection prevention, most governments around the world have recognized the importance of actively regulating the public's behaviour by enforcing infection prevention practices… When people stay at home and only enter public spaces infrequently and for short periods of time, the transmission rate of [COVID-19] is reduced as the virus is not transmitted from infected people to uninfected people due to a lack of interaction and proximity. There are simply fewer opportunities for the virus to be spread from an infected person to an uninfected person.' [695]

The types of negative externalities justifying the limitation of rights through public health interventions extend beyond infection control and the spread of the virus to include the reduction of the burden on South Africa's resource constrained healthcare system. This was successfully argued in *FITA* where the Court held:

> 'We hold the view that a vigorous attempt to contain the spread of the virus at all costs had to be made especially bearing in mind the high COVID-19 mortality rates and the fact that, as a developing country with limited resources as well as an already overwhelmed healthcare system, South Africa is ill-equipped to survive the full brunt of the pandemic at its peak if no concerted efforts are made to contain the virus. In line with its constitutionally mandated duties to preserve life and provide adequate health care, the State was under a duty to adopt measures to ensure that the already fragile healthcare system was not overwhelmed even further.'[696]

IV. FACTORS INFLUENCING THE CONSTITUTIONALITY OF THE TOBACCO BAN: A CASE STUDY

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[694] *Goliath* supra note 309 at para 32.
[695] *Esau* supra note 343 at para 126 referring to expert evidence.
[696] *FITA* supra note 350 at para 42.

The threshold of scientific consensus has been far more difficult to obtain during the COVID-19 pandemic. The litigation challenging the constitutionality of the ban on the sale of tobacco products provide an interesting case study to consider the evidence needed to justify such a ban. In both cases, the central contention was that the tobacco ban was irrational and not proportional. Specifically, in *FITA*, the contention from the applicants was that-

> 'health hazards cannot justify the total prohibition of cigarettes and tobacco sales. FITA's case reduced to its bare essentials is that the ends sought to be achieved by the Minister bear no relationship to the means adopted by her …"[A]part from there being no rational basis for the prohibition … there has been no consideration given to proportionality. The prohibition is also out of step with the vast majority of countries throughout the world. There is also not any rational consideration given to the enormous harm that has been and continues to be occasioned to not only the economy, employment, livelihoods, but also to the health and safety of individuals".'[697]

In both *FITA* and *BAT III*, the applicants also challenged the legality of the ban on tobacco products. As a result, the relation between the limitation occasioned by the ban and the objective of the ban was central to determining the case.

Interestingly, the experts involved in both cases acknowledged that the evidence on COVID-19 was still developing, yet the Court's treatment of the scientific evidence and lack of consensus differed substantially in the two judgments. In both *FITA* and *BAT III*, the central question was framed around whether the ban on tobacco products served the goal of reducing strain on the healthcare system and saving lives.[698] In *FITA*, the Court acknowledged that this question did not require that the ban be the most suitable means to achieve this goal:

> 'In determining whether a link exists between the purpose and the means chosen to achieve such purpose, it should be reiterated that the means opted for by the Minister need not be the best nor the most suitable means through which the purpose may have been attained as the discretion to choose suitable means is that of the repository of public power. The exercise of the Minister's public power in this regard is not susceptible to review on the ground of irrationality unless there is no rational link between the chosen means and the objective for which power was conferred. All that we have to determine as a Court is whether a rational connection between a legitimate governmental purpose (i.e. containing the spread of the virus and saving lives) and the means chosen (i.e. banning the sale of all tobacco products) exists.'[699]

To substantiate the decision to ban tobacco, the Minister of COGTA referred to evidence showing the link between smoking and the risk of developing severe COVID-19, as

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[697] Ibid at paras 13-14.

[698] Ibid at para 29 where the Court stated:

> 'It is against this backdrop that the rationality of the Minister's decision to ban the sale of tobacco products has to be determined. If the end sought to be achieved by imposing a ban on the sale of all tobacco products is to "save lives and health and to reduce the potential strain on the health care system", does the ban, as the means adopted by the Minister, assist in achieving the stated objective? Put differently, is there a rational connection between a legitimate governmental purpose (i.e. saving lives and health and preventing the overwhelming of the country's health care facilities) and the means chosen (banning the sale of all tobacco products)? A related question is whether the evidence relied on by the Minister sufficiently justifies her decision to ban the sale of tobacco products and cigarettes.'

[699] Ibid at para 28.

well as ongoing studies conducted by the WHO which suggested that smokers are more susceptible to developing severe disease and even death. Throughout the evidence presented, the Minister did state that the evidence was not conclusive but was nonetheless suggestive that smoking contributed to severe COVID-19.[700] Though the Minister was unable to provide evidence of consensus, there was evidence of a 'clear association' from the WHO and other sources:

> 'the WHO records that "the available evidence suggests that smoking is associated with increased severity of disease and death in hospitalized COVID-19 patients." Relying on expert reports and opinions from various experts, the Minister submits that the overall consensus is that there is a "clear association" between cigarette smoking and poor outcomes in COVID-19 and that "the weight of the available evidence confirmed that smoking was associated with severe COVID-19 disease notwithstanding outlier studies that found otherwise." On the authority of the various expert views and opinions, the Minister concludes that smoking is a risk factor for the progression of COVID-19 with smokers having up to twice the odds of COVID-19 progression.'[701]

The applicant, FITA, challenged this evidence and called upon the Court to make a determination as to which party's evidence was more persuasive.[702] The Court specifically rejected this request, indicated that determining which evidence ought to prevail was not a question before the Court in making a determination as to the legality of the ban.[703] Instead, the Court found it was enjoined to make a determination only on whether the evidence presented by the Minister provided 'a sufficient rational basis for the Minister to outlaw the sale of tobacco products and cigarettes, as a means of curbing the COVID-19 virus spread and preventing a strain on the country's health care facilities'.[704] In declining to make a determination on the evidence, however, the Court did recognise that the evidence may have a bearing on the rationality of the decision being assessed, stating:

> 'Although a legitimate governmental purpose may exist, if the evidence relied on does not speak to the objective sought to be achieved by imposing the ban, the exercise of public power through the tobacco ban may very well be arbitrary and stand to be set aside. It is not our task, in line with the principle of legality, to undertake an in-depth comparison as to which of the parties' medical research reports and opinions are better or more cogent than that of the other.'[705]

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[700] Ibid at para 36 which states

> 'She points out that, although studies around the potential link between the use of tobacco products and COVID-19 *are still being undertaken*, from the medical literature that has been consulted by her thus far, the evidence shows that the use of tobacco products increases not only the risk of transmission of COVID-19, but also the risk of developing a more severe form of the disease." and at para 37 where it states "the Minister further states that available studies conducted by the World Health Organization ("the WHO") also suggest that — *though not as yet conclusive as research is ongoing* — smokers are at a higher risk of developing severe diseases and death.' (emphasis added).

[701] Ibid at para 38.
[702] Ibid at para 40.
[703] Ibid at para 41.
[704] Ibid.
[705] Ibid.

Similarly, in *BAT III,* available evidence at the time had illustrated that there was a link between smoking and an increased risk of contracting and developing severe COVID-19.[706] In addition, the expert evidence which was very similar to that presented in *FITA* argued that smoking was linked to the development of other NCDs, and that these increased risks create a strain on the public healthcare system.[707] Importantly, the expert evidence acknowledged that the link between reducing the public health risk, namely the risk of developing severe COVID-19, and the intervention, namely the ban on sales of tobacco products with the aim of reducing consumption of tobacco, had not been established. The evidence provided also underscored the broader public health harms of tobacco consumption beyond COVID-19 and the benefits of cessation:

> 'Given the newness of COVID-19, there is not yet enough data to assess whether and/or to what extent the chance of infection or disease progression decreases when a person quits smoking. However, the benefits of quitting smoking are both immediate and long-term, reducing the risk of tobacco-related diseases and improving general health. For example, people with diabetes who quit have the immediate benefit of having better control over their sugar levels and others generally can breathe better. The US Centres for Disease Control and Prevention reports that within the first 20 minutes of quitting smoking the smoker's heart rate drops; within 12 hours, the carbon monoxide level in the blood drops to normal and within 2 weeks to 3 months the risk of heart attack drops and lung function begins to improve. Quitting smoking also immediately benefits children and non-smokers who are exposed to the second-hand smoke of active smokers.'[708]

However, the Court was not persuaded by the evidence presented by the government's witnesses and dismissed the evidence presented: 'The evidence presented on behalf of the Minister has not dealt with the matter satisfactorily. As argued, a fighting chance claim does not constitute a discharge of the burden of proof'.[709] This stands in direct contrast to the reasoning in *FITA,* where the Court upheld the ban on the basis that the Minister had considered 'all relevant medical literature'.[710]

The Court in *BAT III* then considered whether the limitation could be justified based on lessening the burden on the healthcare system. The major distinction between the Court's reasoning in *BAT III* compared to *FITA* was how the lack of scientific consensus was treated. In *BAT III*, the Court treated the lack of scientific consensus as a basis on which to find the

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[706] *BAT III* supra note 349 at para 98.

[707] Ibid at para 99 where the court stated:

> 'These increased risks, in turn, translate to an increased risk of strain on the public health system: the more people who contract COVID19, the greater the strain on the public health system and the more people who contract a more severe form of COVID-19, the greater the pressure will be on our hospitals - COVID-19 hospitalisations are known to last from 8 to 16 days depending on the severity of the patient's symptoms.'

[708] *BAT III* supra note 349 at para 25.

[709] Ibid at para 166.

[710] *FITA* supra note 350 at para 53 where the Court's reasoning in full reads

> 'As such, having had regard to the Minister's submissions, we are satisfied that in arriving at the decision to impose the ban, the Minister considered all of the relevant medical literature — even evidence that may have been at odds with the view linking high COVID-19 virus progression amongst smokers when compared with non-smokers. This fortifies our view that the objectivity requirement has been fulfilled.'

limitation of rights unjustifiable. For example, the Court referenced the WHO's scientific brief on tobacco use as a basis to highlight the lack of peer reviewed studies. On this lack of evidence, the Court said the following:

> 'The scientific evidence relied upon by the Respondents is also far from conclusive. The WHO scientific brief on Smoking and COVI0 -19 dated 30 June 2020 reports that there are no peer-reviewed studies that directly estimate the risk of hospitalisation with COVID-19 among smokers. It also states that there are no peer-reviewed studies that have evaluated the risk of SARS-CoV-2 infection among smokers. Furthermore, the scientific evidence addressing the impact of the cessation of smoking on severe COVID-19 is more tenuous. The scientific evidence stated that as a result of the newness of COVID-19, there is not yet enough data to assess whether and/or to what extent the chance of infection or disease progression decreases when a person quits smoking. There is also substantial literature that confirms that smoking risk for severe COVID-19 exists among both current and former smokers.'[711]

In the context of the *BAT III* decision, the lack of evidence led the Court to find that the Minister of COGTA had failed to show that the tobacco ban fulfilled the objectives outlined in the DMA and, thus, the regulation banning sales of tobacco products was ultra vires.[712] Specifically, the Court held that if cessation of smoking would not reduce the risk of transmitting COVID-19 or developing severe COVID-19, then the objective of the prohibition could not be achieved through that prohibition.[713] This meant the relation between the limitation and its purpose had not been proven, and as a result the limitation of constitutional rights could not be justified.[714] In this regard, the Court summarised their position as follows:

> 'As indicated, if stopping smoking does not hold benefits as regards COVID-19 disease progression (as opposed to general improvements to health), it means that the objective of the prohibition will not be achieved and that the Minister has failed to justify the limitation of constitutional rights. Accordingly, the constitutional rights of smokers that have been referred to, were being limited while there was no evidence to show that to stop smoking would rectify and adjust the anticipated Covid-related health risks on which the Minister relied."[715]

The reasoning in *BAT III* stands in stark contrast with the reasoning in *FITA,* which placed significantly more weight on the necessity of the intervention and the impact of COVID-19 on the healthcare system. In addition, the Court in *FITA* highlighted the link between the tobacco ban as a public health intervention and the state's obligations under other constitutional rights stating:

> 'We hold the view that a vigorous attempt to contain the spread of the virus at all costs had to be made especially bearing in mind the high COVID-19 mortality rates and the fact that, as a

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[711] *BAT III* supra note 349 at para 205.
[712] Ibid at para 206.

> 'In the circumstances, the Respondents have not shown that Regulation 45 reduced or acted to reduce the strain on the health care system. Therefore, the Respondents have not shown that Regulation 45 was necessary or that it fulfilled and/or furthered the objectives set out in section 27 (2) (n). Therefore, the jurisdictional facts required for the authorisation of Regulation 45 in terms of section 27 (2) (n) are absent and consequently it follows that regulation is ultra vires'

[713] Ibid at para 169.
[714] Ibid.
[715] Ibid.

> developing country with limited resources as well as an already overwhelmed healthcare system, South Africa is ill-equipped to survive the full brunt of the pandemic at its peak if no concerted efforts are made to contain the virus. In line with its constitutionally mandated duties to preserve life and provide adequate health care, the State was under a duty to adopt measures to ensure that the already fragile healthcare system was not overwhelmed even further.'[716]

In this regard, the decision in *FITA* aligns with other decisions where the evidentiary threshold was lower and the limitation was subject to a less strict test because the limitation was judged to protect and promote other rights. In contrast, the Court in *BAT III* placed greater emphasis on the rights being limited by the tobacco ban, finding that the ban infringed several rights, including the right to bodily integrity and the right not to be arbitrarily deprived of property. The Court's decision in *BAT III* undoubtedly aligned closely with the ongoing narratives around autonomy and individual freedom, which are also frequently invoked to oppose NCD prevention efforts.

> 'Section 12 (2) of the Constitution provides that "[e]veryone has the right to bodily and psychological integrity", which includes the right to "security in and control over their body". This is the right of adults to make autonomous decisions regarding how they want to maintain their bodily and psychological integrity during times of stress, and it cannot be disputed and has been documented, that the pandemic and lockdown periods and the results thereof, have contributed to psychological pressure on the general population, leaving many with feelings of immense stress, anxiety and insecurity. Undoubtedly, as argued, "control" includes the protection of one's autonomy, or bodily self-determination against interference and a law that limits, inter alia, the autonomy to take steps, including smoking, to manage one's stress levels and mental health issues. Not being allowed to do so, even if their conduct may harm their health, constitutes an infringement of this right.'[717]

This characterisation was central in informing the standard against which the intervention was assessed and the degree of deference afforded to government. The level of deference the Court showed to government's decision-making, and the test of rationality versus proportionality, constitute the greatest differences between the approaches in *FITA* and *BAT III*.

In *FITA*, the Court emphasised the need for judicial deference in polycentric decision-making, even where the evidence was not as compelling as it could have been. In this regard, the Court stated:

> 'Could the Minister have tendered "better, more convincing" and "less limited" evidence? Perhaps. But this is not the question before us. As pointed out by the Minister in her papers, it is not for this Court to determine which of the various studies and reports are "better evidence" and could have led to the adoption of "better means". The question is rather whether the evidence considered by the Minister as it stands provides a rational basis for the prohibition. Put differently, the question before the Court is rather, having regard to the evidence considered and relied on by the Minister, could it be said that there is enough to conclude that the prohibition placed on the sale of tobacco products is justified? In our view

[716] *FITA* supra note 350 at para 42.
[717] Ibid at para 145.

the answer is clearly in the affirmative. We must also point out at this juncture the relevant and important principle that where the decision in question relates to technical subject matter, a Court must exercise a measure of judicial deference when assessing whether the impugned decision is irrational. As a separate and distinct branch of government, it is important for the judiciary to remain cognizant of the nuanced role that it plays as a custodian of the law and not overreach and thus exceed the limits of judicial authority so as to not offend the doctrine of separation of powers.'[718]

The reasoning in *BAT III* was less deferent to the Minister's contentions, interrogating costs and harms of the ban relative to its benefits under the auspices of assessing the proportionality of the ban, not merely its rationality. In this regard, the Court stated,

> 'We have already found that the evidence does not support a conclusion that Regulation 45 would reduce its stated purpose, namely, to reduce the incidence of smoking. Mr Cockrell argued that even [if] we found that a 10% to 15% reduction in the number of smokers is sufficient for Regulation 45 to achieve its stated purpose, the Minister would still have to show that the benefits of Regulation 45 exceed the harm that it causes. In terms of section 36(1) the court is required "to weigh the extent of the limitation of the right against the purpose for which the legislation was enacted". This is explained in *S v Makwanyane and Another* as the "... weighing up of competing values, and ultimately an assessment based on proportionality … which calls for the balancing of different interests".'[719]

In assessing this proportionality, the Court placed significant weight on evidence which calculated that the tobacco ban would free up only 16 ICU beds at a given time, in contrast to the millions of rands lost in excise duty and the potential economic harm to businesses.[720] The Court ultimately held that the limitation of rights could not be justified under section 36:

> 'As can be discerned from what is set out above, the Minister has not discharged the onus of showing that the violation of the constitutional rights of smokers is justified in terms of section 36(1) of the Constitution. On the Minister's own version, the benefit of Regulation 45 is that at any one time there may be 16 fewer patients requiring hospitalisation in ICU than would

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[718] *FITA* supra note 350 at paras 45-6.
[719] *BAT III* supra note 349 at para 174.
[720] Ibid at para 176 where the Court held

> 'The upshot of these calculations is that the prohibition on smoking is likely to free up approximately 16 ICU beds at any one time across the entire country. According to the applicants, this extraordinarily small number does not begin to justify the massive harm that is caused by Regulation 45. The proper context of the harm must include the billions of rand that are lost to the fiscus by virtue of the fact that illicit cigarette sales are burgeoning. According to the applicants the loss of excise duty to the fiscus is approximately R35 million per day. In response, the Genesis Report says that the loss to the fiscus in the form of excise duties was R2.2 billion during the period from 27 March 2020 to 22 May 2020. That is a loss of almost R38 million per day according to the Minister's own expert. It cannot be disputed that the harm includes the damage caused to the various participants in the supply chain for smoking and vaping products as attested to in their affidavits. Some of them will go out of business. Those that do not go out of business will suffer losses and may have to retrench employees. In addition, the harm includes the fact that illicit cigarettes contain harmful substances not found in licit cigarettes. According to Dr Morjaria, forced cessation may have adverse impacts on smokers. Moreover, there is some evidence to show that former smokers have a worse Covid-19 experience than current smokers.'

otherwise have been the case. It therefore is plain that the disadvantages of the ban far outweigh the advantages in so far as smokers are concerned.'[721]

This case study of the *BAT III* and *FITA* decisions highlights how the application of the section 36 considerations may vary considerably in terms of how a court assesses and weighs various components – particularly the evidence to determine the necessity of the intervention, the extent to which the limitation infringes on other rights, and the deference the Court shows to the Executive's discretion. This highlights the highly variable nature of a section 36 analysis in any public health context.

V. APPLICATION TO NCD PREVENTION INTERVENTIONS

The application of section 36 can thus be highly variable. In addition, the justifiability of the limitation will also be influenced by the types of rights being limited, the extent of the limitation and the nature of the intervention being analysed. This means that the section 36 limitations analysis in the case of NCD prevention interventions will vary from intervention to intervention. However, the considerations above highlight components that should be dealt with and offer potential guidance on how a limitation may be justified for NCD prevention. This section will briefly outline how these factors should be considered and argued to justify the limitation of individual rights for the purposes of NCD prevention.

In considering most of the components outlined above, the public health burden and severity of the NCD epidemic should provide a sufficient basis to justify the limitation of rights. Prior to COVID-19, the NCD epidemic was set to become the primary cause of death across sub-Saharan Africa in the next decade.[722] Though NCDs were not perceived as an urgent concern, their contribution to South Africa's quadruple burden of disease underscores the severity of this epidemic as a basis to justify substantial incursions on individual rights for public health objectives.[723] As discussed at length in the preceding Chapters, the rights being protected and promoted through the prevention of NCDs also offer a further basis to justify the limitation of individual rights.

When it comes to the other components of the analysis, the distinction between the NCD epidemic and the various other epidemics at the centre of the cases discussed above is of relevance. The primary distinction is the non-communicable nature of the epidemic, which limits the negative externalities that emanate from individual behaviours. When an individual engages in behaviour that puts them at risk for developing NCDs, this does not have a bearing on the risk others have of developing NCDs, and the individual with NCDs cannot spread or infect others with the disease.[724] However, there remains a significant externality to NCDs: the increased burden on the healthcare system.[725] The chronic nature of NCDs, coupled with the resource intensive treatments they require, have the potential to cripple South Africa's

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[721] Ibid at para 177.
[722] Jean Joel Bigna and Jean Jacques Noubiap 'The Rising Burden of Non-Communicable Diseases in Sub-Saharan Africa' (2019) 7 *The Lancet Global Health* e1295 at 1295.
[723] Pillay-van Wyk et al op cit note 14 at e650.
[724] Spires et al op cit note 24.
[725] Boutayeb and Boutayeb op cit note 4.

healthcare system.[726] In this regard, negative externalities may provide a further basis to justify the limitation of individual rights.

Similarly, the imperative to avoid this potential impact on the healthcare system may provide a means to underscore and illustrate the necessity of *preventative* actions, even those seated outside the healthcare system, and further justify the limitation on individual rights emanating from NCD prevention efforts.

The most challenging component of the section 36 analysis when it comes to NCD prevention remains the evidence of the effectiveness of the interventions, particularly in the context of assessing the relation between the limitation and its purpose. Many NCD prevention interventions target underlying risk factors and determinants of health, resulting in a diffuse benefit that may not be easily quantifiable and measurable.[727] Moreover, many of the interventions have not been implemented elsewhere or subject to a regulatory approval process verifying their effectiveness. For this reason, robust scientific evidence illustrating the effectiveness of the intervention in reducing the NCD burden is a critical component of justifying the limitation of rights that flows from NCD prevention efforts.

VI. CONCLUSION

This Chapter has outlined how a section 36 limitations analysis applies to public health interventions and has explored the particular considerations that influence whether a limitation can be considered justifiable. While the test under section 36 is inherently flexible, there is a clear pathway to justify the limitation of individual rights to achieve the public health goals of NCD prevention, provided a decision-maker adequately considers these factors and ensures its reasoning is robust. This concludes the development and application of a constitutional rights-based approach to NCD prevention in South Africa, illustrating the possibility of invoking constitutional rights to support and guide the adoption and implementation of further interventions to prevent NCDs. The next Chapter will deal briefly with how these interventions can be developed and assessed by decision-makers.

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[726] Agnes Erzse, Nicholas Stacey, Lumbwe Chola et al'The Direct Medical Cost of Type 2 Diabetes Mellitus in South Africa: A Cost of Illness Study' (2019) 12 *Global Health Action* 1636611.

[727] Adrian Bauman and Don Nutbeam 'Planning and Evaluating Population Interventions to Reduce Noncommunicable Disease Risk–Reconciling Complexity and Scientific Rigour' (2014) 25 *Public Health Res Pract* e2511402; Sarah Mounsey, Lennert Veerman, Stephen Jan et al 'The Macroeconomic Impacts of Diet-Related Fiscal Policy for NCD Prevention: A Systematic Review' (2020) 37 *Economics & Human Biology* 100854.

CHAPTER 8
CONCLUSION AND RECOMMENDATIONS

I. INTRODUCTION

'Human Rights are more than noble ideas. They have the power to change lives.'
- Tedros Adhanom Ghebreyesus, Director General of the World Health Organisation[728]

The application of HR frameworks to the NCD epidemic is undoubtedly a neglected area, particularly in the context of food- and obesity-related NCDs. Yet, there is immense and transformative power in utilising human and constitutional rights to guide and buttress an NCD response. While South Africa has some of the most comprehensive and progressive NCD prevention policies in the world, these policies have not been underpinned by constitutional rights. Campaigns to reduce NCDs have been susceptible to increasing opposition from industry actors. Whilst South African did not, per se, need an HR-based approach to NCD prevention in the initial stages of its policy and legal response to the epidemic, an approach anchored in constitutional rights could be of assistance in guiding the next phase of our response. All of these serve the ultimate objective of protecting and improving the health of South Africans, and it is this goal which gives HR the power to change lives, particularly in the context of public health and epidemics.

This thesis has investigated the application of a HR framework to the NCD epidemic and, in doing so, has comprehensively explored the relationship between constitutional rights and public health through various epidemics. In this sense, the application of constitutional rights to the NCD epidemic continues the tradition of using HR to support epidemic responses and improve public health. The lessons drawn from this thesis have broad application not only to NCD prevention, but also to future pandemics. These Chapters have traversed the content of section 27 of the South Africa Constitution, specifically in relation to the social determinants of health (including food, a healthy environment and access to healthcare), creating and concretising a broader right to health within the framework of the Constitution. This thesis has challenged the traditional framing of the relationship between individual rights and NCD prevention efforts which accord individual autonomy primacy, and instead offered a nuanced view which can significantly influence the way in which NCD interventions should be analysed. It has also offered guidance for managing 'colliding rights', considering how to balance those rights supporting NCD prevention with those rights which are infringed by interventions, and investigating what factors should be considered when analysing public health interventions through the lens of section 36. In this final Chapter, I will briefly summarise the key findings from the preceding Chapters before concluding with final thoughts and recommendations on the application of a constitutional rights-based approach to NCD prevention in South Africa.

[728] Lawrence O. Gostin and Benajmin Mason-Meier *Foundations of Global Health & Human Rights* (2020) at i.

II. SUMMARY OF MAIN CONCLUSIONS

This thesis proceeded from the starting point that there is a growing NCD epidemic in South Africa, and that this burden of disease may be significantly reduced and prevented through the adoption of legal and policy interventions. It adopted the premise that laws are particularly well suited to prevent NCDs if appropriately adopted and implemented. However, there are several impediments to the adoption and implementation of these measures, some examples of which were described in Chapter 1 (such as the extensive opposition to the adoption of an SSB tax in South Africa). This outlines the possible solutions to the NCD epidemic in the form of laws and policies but sketches the impediments to implementing these solutions. Such impediments illustrate the particular need for a constitutional rights-based approach to the epidemic.

Chapter 2 outlined in some detail the differing HR-based approaches to NCDs suggested by different scholars. While the literature was explored in detail, it remains striking how little scholarship exists on the topic of HR and NCDs, with a significant proportion of both scholarship and international instruments focusing on the treatment and diagnosis of NCDs with very little emphasis on NCD prevention or risk factors as underlying determinants of health. What emerged from the literature is the need to concretise the HR-based approach to NCD prevention by identifying specific rights, entitlements and obligations that will support action on NCDs. Most of the existing literature has focused on the right to health and the right to food as potential rights to support an HR-based approach to NCDs, and these thus became the primary focus of this thesis. In Chapters 3 and 4, I attempted to develop the content of these two rights in relation to the prevention of NCDs.

In Chapter 3, I began by delineating the scope of the right to health beyond healthcare under international law. While there has been a significant emphasis on pharmaceutical interventions and access to healthcare services, the right to health also encompasses underlying determinants of health and the antecedents of good health. While section 27(1)(a) encompasses a right to healthcare, there are other antecedents of good health protected under other rights such as the right to a healthy environment under section 24 of the Constitution. Some scholars have suggested superficially that the various socio-economic rights contained in the Bill of Rights may be read to create a composite right to health under the Constitution. I attempted, in this Chapter, to interrogate this idea and more fully develop the content of section 27(1)(a) in this regard. Through the examination of case law related to section 27 and health more broadly, it emerged that the collectivist approach adopted by the courts in interpreting the right to healthcare enables the right to function more broadly as a right to health, where it can operate to support action that lessens the burden on the healthcare system. This approach was initially applied to public health interventions outside the healthcare sector in the cases concerning a ban on tobacco advertising as an NCD prevention measure, and expanded upon significantly in cases challenging the COVID-19 response. In considering the constitutionality of NPIs to prevent COVID-19, the courts expanded on the application of section 27(1)(a) to public health interventions, including those outside the healthcare sector. Here, section 27(1)(a), sometimes in conjunction with other rights such as the right to life and bodily integrity, provides a basis for supporting actions that promote a broader right to health.

Chapter 4 considered the application of the right to food to NCD prevention with a focus on how the right applies to issues of healthfulness of food and overnutrition. This is particularly

relevant in the South African context where a changing food environment is influencing diets to shift from healthier traditional diets to unhealthier, more processed Western diets. Food insecurity and undernutrition has been the focus of much of the scholarship on the right to food under both South African and international law. However, there is recognition that the right to food and the right to health are linked, and thus to some extent the content of the right to food may be informed by the understanding that food is an underlying determinant of health. Indeed, in many contexts the right to food is so interconnected with other rights that it finds expression as a component of the right to life rather than as a self-standing right. Though South Africa's Constitution recognises a self-standing right to food, it has often been realised and protected indirectly through the protection and promotion of other rights, which underscores its relationship with other rights. This Chapter also explored the specific components of the right to sufficient food and attempted to delineate the scope of the South African right to 'sufficient' food in contrast to the international right to 'adequate' food. It ultimately reflected the content of the section 27(1)(b) right as including components of financial accessibility, cultural acceptability and, as I argue, substantively the same content as the right to food under international law. Finally, with reliance on Brand's conceptualisation of the right to food, I contended that the content of the right under section 27(1)(b) includes nutritional composition and healthfulness of diet, which can support action on NCD prevention, particularly when read in conjunction with the right to healthcare under section 27(1)(a).

To realise the value of an HR-based approach to NCD prevention as an accountability mechanism to guide government action, it is also necessary to concretise the obligations that emanate from these rights. In Chapter 5, I drew upon Eide, Oshaug and Eide's framework for nutrition and food security to develop obligations for NCD prevention within the respect, promote, fulfil and protect rubric under section 7 of the Constitution. Under the components of physical accessibility, financial accessibility and nutritional adequacy, there are obligations on government to take various actions to prevent NCDs. Beyond this, the obligation to protect also offers a means to prevent industry actors from engaging in behaviours which may harm the health of citizens and thus requires governments to act to regulate these producers.

After establishing that there are entitlements and obligations under constitutional rights which support NCD prevention efforts, it was necessary to then consider the opposite, namely, where rights may be infringed and thus impede NCD prevention efforts. There has generally been an over-emphasis on the limitation of rights emanating from NCD prevention efforts with very little focus on how these interventions promote and protect rights, such as those described in Chapters 3 and 4. For this reason, Chapter 6 began by interrogating the relationship between public health interventions, particularly those related to NCD prevention, and HR. The first section of the Chapter underscored the need to frame the relationship in a nuanced manner to recognise both supportive and limited rights. It illustrated how this framing can significantly impact the section 36 analysis of these interventions. The next section then utilised the historical relationship between public health and HR as a framework to understand the operation of this relationship in South African jurisprudence. This analysis illustrated that seeing rights as supportive of public health interventions is most closely aligned with the approach adopted in various epidemics. COVID-19 jurisprudence is more varied but highlights the importance of framing, since where rights were identified as supportive of public health, the limitations emanating from the impugned or challenged interventions could be more easily justified under section 36.

Chapter 7 elaborated on the application of section 36 to public health interventions, identifying the considerations that influence a section 36 analysis. In reviewing cases concerning the adoption of public health measures and constitutional rights, some common considerations and principles emerged amidst this flexibility. These five broad considerations are: (a) the severity of the pandemic concerned; (b) the effectiveness of the intervention limiting rights; (c) the necessity of the intervention in preventing the epidemic; (d) the impact the intervention has on other rights; and, (e) the negative externalities of the individual conduct being subject to limitation. The NCD epidemic meets many of these factors in constituting a severe epidemic that can place a significant burden on the healthcare system if not prevented. This burden can, as was the case with COVID-19, overwhelm the healthcare system and negatively impact others in the community. This may be a basis upon which a decision-maker can demonstrate the necessity of prevention interventions and the negative externalities of the epidemic. The impact of these interventions in promoting and protecting other rights, specifically the right to health and food, may provide a further basis upon which the limitation of rights can be justified. The point of concern which remains for these novel interventions is the evidence of their effectiveness and the benefits they yield relative the extent to which they limit rights. The assessment of these factors has varied considerably, occasionally resulting in conflicting assessments and analysis. Consequently, there is a need for robust decision-making based on strong evidence to ensure NCD prevention efforts withstand the test under section 36.

III. RECOMMENDATIONS AND CONCLUDING REMARKS

This thesis has sought to make a novel contribution to the literature on public health and HR through the development and application of a human rights-based approach to NCD prevention anchored in the South African Constitution. While the scholarship on obesity prevention and HR continues to develop, the development of a concrete and context-specific approach can offer value to NCD prevention efforts and become an important advocacy tool.

While South Africa has implemented a number of novel and pioneering NCD prevention policies and laws, including limits on trans-fats and sodium, and a tax on SSBs (see Table 2 for details of the implementation), these are just the starting point in the campaign to turn the tide on this growing epidemic. What is needed now is the adoption and implementation of comprehensive policies to improve access to healthier foods and to reduce the availability, accessibility and acceptability of unhealthy food options. This could include implementation of further Global Action Plan measures such as comprehensive restrictions on the marketing of unhealthy foods (which is considered of significant importance in shaping behaviours around the consumption of unhealthy foods).

In addition, the national Department of Health has delayed the process of developing and implementing simplified nutrition labelling since the publication of the draft R429 in 2016. The application of a constitutional rights framework to this process may enable policy to be responsive to constitutional obligations while providing a mechanism to hold government accountable and prompt further action. In addition, this HR framework could be used by civil society organisations to reshape narratives about NCD prevention as a matter of public health rather than an issue of individual choice which is outside the concern and reach of the state.

Perhaps of greatest utility is the ability of the constitutional rights framework to buttress efforts to regulate the producers of unhealthy commodities and protect individual rights. The application and further development of the horizontal obligations that emanate from these rights can be an effective means to address and curb industry opposition and interference in NCD prevention policies. However, in adopting and implementing NCD prevention policies, decision makers must be mindful of the rights being limited by those interventions and seek to ensure these limitations are justifiable under section 36.

A constitutional rights-based approach to NCD prevention in South Africa has the potential to support further pioneering policies and interventions to improve population health and realise the potential of constitutional and HR to change people's lives.

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