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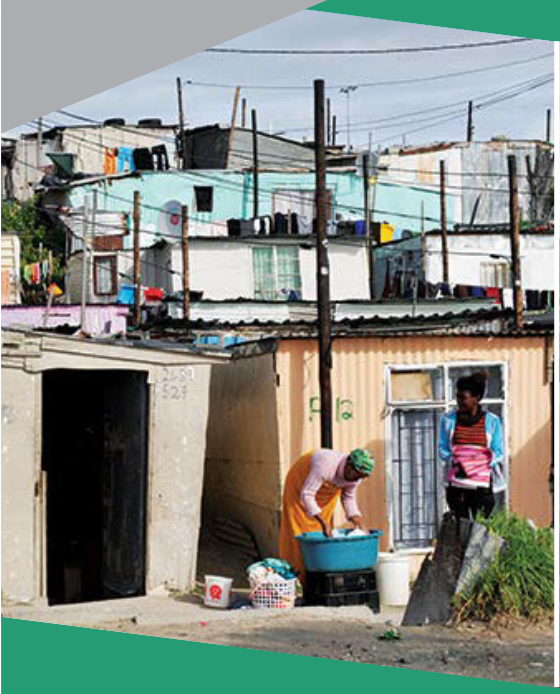

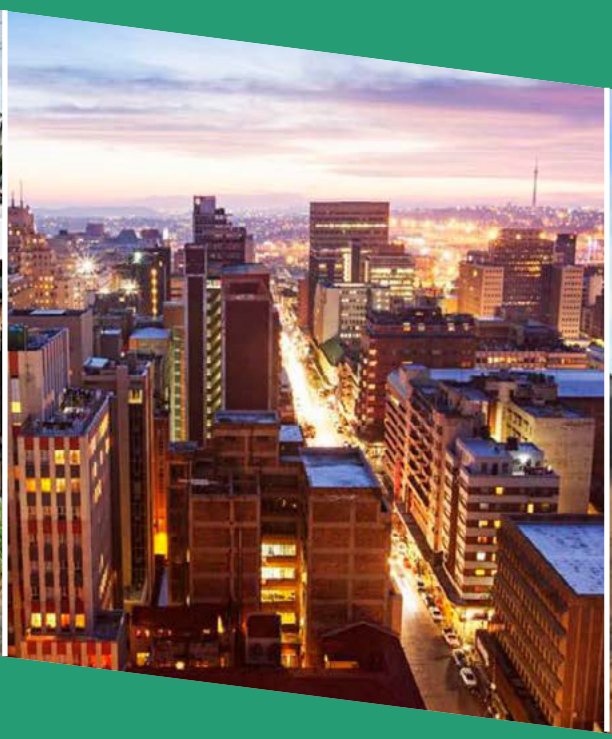

# ESR REVIEW

## Economic & Social Rights Review in Africa

ENSURING **RIGHTS** MAKE REAL **CHANGE**

## SPECIAL EDITION ON NON-COMMUNICABLE DISEASES

DULLAH OMAR INSTITUTE
FOR CONSTITUTIONAL LAW, GOVERNANCE AND HUMAN RIGHTS

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# Editorial

Welcome to the first *ESR Review Special Edition*, part of a series on non-communicable diseases (NCDs) brought to you in collaboration with the Global Center for Legal Innovation on Food Environments at the O'Neill Institute for National and Global Health Law, Georgetown University Law Center.

NCDs such as hypertension, cardiovascular diseases, diabetes and cancer have been in the spotlight due to Covid-19, as people with these comorbidities are at heightened risk of serious ill-health, disease and death. A major cause of premature death and disability, NCDs are particularly rife in developing countries. Globally, an estimated 41 million people die from NCDs every year, with 80 per cent of deaths occurring in low- and middle-income countries. The rise of NCDs also presents a huge economic burden worldwide due to the cost of management as well as loss of output.

The increasing incidence of NCDs is driven largely by tobacco use, physical inactivity, harmful alcohol consumption and unhealthy diets. Unhealthy diets have garnered much attention, especially for the negative influence of the food industry in sustaining unhealthy food environments. Countries have been urged to take legal, regulatory, and fiscal steps to curtail these activities with a view to creating food environments in which individuals and households can easily access healthy food.

Against this backdrop, our special edition presents contributions focusing on the prevention of diet-related NCDs.

The first article explores NCD prevention through an equitable food system in South Africa, highlighting current opportunities and challenges in this regard. The second provides an interesting perspective on the beverage industry in Mexico, which launched a digital campaign to stop approval of the front-of-package labelling system. The third article explores legal issues around the adoption of simplified nutrition labelling in South Africa, focusing on an analysis of draft regulation R429. The fourth article offers a critique of the National Strategic Plan for the Prevention and Control of NCDs 2022–2027, as part of which it assesses policy priorities for addressing unhealthy diets.

This edition also features an interview with Dr Vicki Pinkney-Atkinson, Director of the South African Non-Communicable Disease Alliance (SANCDA), who provides insight into the state of NCDs in the country. In the updates section, we share observations on the complaint SANCDA submitted to the South African Human Rights Commission.

We hope you find this issue stimulating and useful in advocacy for the right to health. We wish to thank the anonymous peer reviewers and our guest authors for their insightful contributions.

*Aisosa Jennifer Omoruyi and Paula Knipe*
**Guest Editors**

# INTRODUCTION

# The ESR special Edition on NCDs

*Margherita Cinà and Isabel Barbosa*

*Noncommunicable diseases (NCDs), including cardiovascular diseases, diabetes, chronic lung disease, and cancers, kill 41 million people annually, with this growing burden disproportionately impacting on low- and middle-income countries (WHO 2022a). Critically, NCDs are predicted to become the biggest public health crisis in South Africa by 2030 (Hofman 2014). Within this context, we are pleased to introduce this special issue of the ESR Review, which aims to provide insight into how legal interventions play a pivotal role in tackling NCDs in South Africa and beyond.*

Health is the product of a complex interaction between biological factors and a host of social, commercial, and legal determinants (WHO 2022b; Gostin et al. 2019; WHO 2021a). As NCDs are largely attributable to the risk factors of tobacco use, harmful use of alcohol, and unhealthy diets (WHO 2022), the framework of the commercial determinants of health has been particularly relevant for understanding the power that corporations wield in creating unhealthy environments, and, in turn, considering how to address this growing public health crisis.

In a nutshell, this framework explores the private sector activities that influence public health and enable political economic systems and norms (Kickbusch et al. 2016; Mialon 2020). In particular, the tobacco, alcohol, and food and beverage industries have used business, marketing, and political practices to increase people's exposures to unhealthy products while securing political environments that place profit over public health (Kickbusch et al. 2016).

The role of corporations in spurring the NCD-related public health crisis across the world should also be examined in the light of important human rights considerations. In particular, the right to health is enshrined in the International Covenant on Economic, Social and Cultural Rights (article 12), as well as regionally in the African Charter of Human and Peoples' Rights (article 16), both of which have been interpreted to include access not only to health care but also to underlying determinants of health such as adequate and nutritious food (CESCR 2000; ACHPR 2014).

Correspondingly, states have obligations to respect the right to health by not interfering directly or indirectly with its realisation, to protect this right by taking measures to prevent third parties such as corporations from interfering with its enjoyment, and to fulfil this right by adopting appropriate measures which include, for example, legislative, administrative, and budgetary measures (CESCR 2000, para 33).

> **...the commercial determinants of health has been particularly relevant for understanding the power that corporations wield in creating unhealthy environments...**

Understanding the normative content of health and health-related rights, as well as the obligations that the human rights framework imposes on states, is critical in the context of NCD prevention.

To counter industry's negative impact on health outcomes and ensure the realisation of human rights, legal and regulatory interventions are increasingly recognised as effective tools to these ends (Gostin et al. 2019). For example, tobacco control measures, such as smoke-free spaces, plain packaging, and restrictions on tobacco advertising and sponsorship, have gained both prominence and success around the globe, particularly since the ratification of the Framework Convention on Tobacco Control in 2005 (Chung-Hall et al., 2–19).

While this landscape continues to evolve, and as the framework of the commercial determinants of health is strengthened, there have been successes in using legal and regulatory measures to tackle other risk factors to prevent NCDs. With regard to unhealthy diets, these have included regulating nutrition labeling, adopting taxation of sugar-sweetened beverages, and restricting marketing and advertising (WHO-Western Pacific 2022). Against this backdrop, the Global Center for Legal Innovation on Food Environments (Global Center) – housed at the O'Neill Institute for National and Global Health Law at Georgetown University Law Center – was launched in February 2020 to tackle diet-related NCDs through the legal and policy scholarship, capacity-building, and technical assistance (O'Neill Institute for National and Global Health Law).

Working closely with partners around the globe, the Global Center serves as a transnational venue for collaborative research, cross-education, and applied work in the area of food law and policy, with the ultimate goal of strengthening the bridge between academia and practice within this field.

In pursuit of these goals, the Global Center entered into a partnership with the Dullah Omar Institute at the University of Western Cape to bridge both organisations' expertise in food law and policy, grounded on a human rights-based approach. The Dullah Omar Institute has been a critical partner, as demonstrated by this special issue, in strengthening the generation and dissemination of knowledge in the area of food law and policy within South Africa and generally around the world.

**To counter industry's negative impact on health outcomes and ensure the realisation of human rights, legal and regulatory interventions are increasingly recognised as effective tools...**

As South Africa continues to be burdened with high rates of NCDs, and as childhood obesity rates continue to skyrocket (WHO 2021b), there is a need to create and strengthen more spaces where academics and policy-makers can develop and disseminate knowledge, including in the legal field, and create a community that addresses unhealthy food environments in an equitable manner. This special issue of the ESR Review, and the work conducted by the Dullah Omar Institute and other groups across South Africa, is a vital step towards achieving these goals.

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FEATURE

# NCD Prevention through an Equitable Food System in South Africa: Opportunities and Challenges

*Metron Ziga and Abdulrazak Karriem*

## Introduction

*Non-communicable diseases (NCDs) are a leading cause of global mortality, with about 41 million people dying of them annually (WHO 2021). In South Africa, NCDs accounted for 43% of total deaths in 2012, with this increasing to 51% in 2018 (WHO 2014; WHO 2018). The NCD Countdown 2030 report estimates that South Africans have a 51.9% probability of dying from NCDs (Bennett et al. 2020).*

The increasing prevalence in NCDs is largely attributable to unhealthy diets: these generate more disease than smoking, alcohol and physical inactivity combined (Yach et al. 2007 in Puoane 2013). In recent years, the consumption of processed and ultra-processed food and beverages has increased in many African countries, including South Africa (Reardon et al. 2021). Processed and ultra-processed food and beverages are often marketed in a way that appeals to children; they are also affordable and easy to prepare. Most NCDs are 'strongly associated with diet' (Joubert 2012: 148); hence, food systems cannot be divorced from the solutions necessary to tackle the NCD crisis.

Food system inequities are a key driver of NCDs as these restrict the poor's access to healthy food. Food systems are instrumental in shaping consumer food preferences, attitudes and food cultures, and they influence the selection of food that people consume.

The prevalence of food insecurity and malnutrition in South Africa's food system points to the fact of food-system inequity. The country's food system increasingly supplies the highly processed food that fuels the spread of nutrition-related diseases. This increase is largely driven by multinational corporations (using advertising and the appeal of low costs), and is facilitated by weak government regulation (Ho 2021).

An equitable food system can assist in shaping the supportive food environment necessary to promote healthy eating (WHO 2014). While South Africa produces enough food to meet its domestic needs, its high levels of poverty and inequality mean that there is a problem around access to nutritious food (Greenberg 2015).

This article examines food-system inequities, their deep-rooted causes, and the opportunities and challenges that exist in seeking to transition to the

**Processed and ultra-processed food and beverages are often marketed in a way that appeals to children; they are also affordable and easy to prepare.**

more equitable food systems which are necessary for NCD prevention. It emphasises that multi-scale interventions (involving a range of players in the food system) are needed to tackle these inequities. Regulatory and policy frameworks that seek to address food-system inequities need to go beyond food itself and address inequalities in income, in access to resources, and in underlying power relations.

## Evidence of inequities in South Africa

South Africa is considered one of the most food-secure countries in Africa. It produces more than enough food to feed its entire population at a national level (Chakona & Shackleton 2017). However, food security refers to more than the simple availability of food at a national level; it exists only 'when all people, at all times, have physical, social and economic access to sufficient, safe and nutritious food which meets their dietary needs and food preferences for an active and healthy life' (FAO 1996).

More than half of South Africa's population is at risk of hunger, while large numbers do not have access to nutritious food (Samodien et al. 2021; Chakona & Shackleton 2017). According to Stats SA (2019), about 11% (6.5 million) of the population suffers from hunger, while almost one in four children under the age of 5 are stunted and (in stark contrast) one in eight children are overweight (May et al. 2020).

Food insecurity is not an issue of the unavailability of food; rather, it reflects the fact of unequal access to nutritious food and resources, which is rooted in socio-economic inequalities. Poverty is the root cause of food and nutrition insecurity in South Africa. More than half of the population (55%) experiences poverty, while more than 60% of children live in poverty (Samodien et al. 2021; Stats SA 2020). In general, women are less likely to be employed than men, and earn approximately 30% less than their male counterparts, while black Africans earn the lowest wages among all population groups (Stats SA 2020). These basic socio-economic inequalities determine access to nutritious food.

Food insecurity is related to the prevalence of obesity, overweight, and diet-related NCDs such as diabetes and cardiovascular disease. Food and beverages high in calories and fat are more readily available and affordable than fruits and vegetables (Nackers & Appelhans 2013). The affordability and availability of calorie-dense foods are influenced by the aggressive marketing of ultra-processed products by Big Food and Beverage companies (Igumbor et al. 2012).

In fact, eating healthy food is unaffordable for poor South Africans (Samodien et al. 2021), who have to spend almost 50% of their income on food purchases (Crush et al. 2011; Oxfam 2014). There is a strong association between food security, income, and diet quality, with lower food security and income resulting in a decrease in the intake of healthy food (Nackers & Appelhans 2013).

In addition, the poor are much less likely to own the refrigerators which enable the safe storage of fresh and nutritious and fresh food, and so are pushed to resort to the readily available and highly processed and ultra-processed foods that are high in salt, sugar and fats (Joubert 2012) and whose consumption results in much greater levels of vulnerability to NCDs.

At the same time, food insecurity and malnutrition in South Africa are accompanied by a 'nutritional transition' (Popkin 2015). This is characterised by a shift from the traditional diets (which are high in healthy cereal and fibre) to 'Western diets' which are high in (unhealthy) sugar, fats and salt (Greenberg 2015) and contribute to increased levels of NCDs.

**...the poor are much less likely to own the refrigerators which enable the safe storage of fresh and nutritious and fresh food...**

In general, this shift can be attributed to the large commercial entities that dominate the food and beverage sector, often referred to as 'Big Food and Beverage' (Samodien et al. 2021). Big Food and Beverage has been implicated in unhealthy eating for making 'ultra-processed, energy-dense food more available, accessible and appealing to the poor through retail brands, packaging and labelling and by extending retail outlets into poorer areas' (Kroll 2017: 4). Big Food and Beverage corporations also make ultra-processed products more appealing by making them cheap; sponsoring schools or sports events; and through buying celebrity endorsements.

The dramatic increase in the consumption of Coca-Cola products in the country exemplifies the success of Big Food and Beverage tactics to make these high-energy and low-nutrient products affordable, accessible, and desirable to South Africans. In 1992, consumption stood at 130 products per person; it grew to 175 by 1997 and reached 254 in 2010. This is compared to a worldwide average of 89 Coca-Cola products per person per year (Igumbor et al. 2012). At the same time, the rapid expansion of supermarkets in South Africa has accelerated the popularity and consumption of the 'Western' diet.

**While millions of South Africans are food-insecure or at risk of hunger, tonnes of nutritious food are simply discarded and end up in the rubbish dump.**

Joubert (2012) argues that the commercial survival of supermarkets depends largely on their trade in processed and packaged foods. Moreover, food-system inequity is evident in the simple fact that supermarkets stock less-healthy foods in low-income areas, while in wealthier suburbs they stock healthier food (Kroll 2017). Big Food and Beverage and the large supermarket chains are reaping profits at the expense of the health and well-being of the poor.

While millions of South Africans are food-insecure or at risk of hunger, tonnes of nutritious food are simply discarded and end up in the rubbish dump. About a third of the food produced in the country is wasted every year, with fruits, vegetables and cereals accounting for 70% of this food wastage (WWF 2017). The total cost of food wastage is R61.5 billion, equivalent to 2.1% of South Africa's GDP (Oelofse 2015: 6).

Social inequality is evident in the relation of food waste to income. A study in Rustenburg (North West Province) found domestic food waste to be higher in low-income areas (27%) than in middle- and high-income areas, where it stood at 13% and 17%, respectively (WWF 2017: 8). Interestingly, although low-income earners consume less food than their higher-income counterparts, they generate more food waste. This is very likely related to poor storage facilities, and especially the lack of refrigerators.

From the above, the inequity at work in South Africa's food system is incontestable: the high prevalence of NCDs and the fact of food insecurity, malnutrition, and food waste all demonstrate this.

## Food-system transformation: Opportunities and challenges

South Africa has made some progress in developing the food policies necessary to reduce NCDs. However, implementation leaves a lot to be desired. Global studies on the control and prevention of NCDs reveal that policies which favour healthy eating should be population-based and characterised by 'mass media campaigns and transparent food labelling, and, more drastically, through regulation and taxation of unhealthy foods' (Samodien et al. 2021: 2). In addition, other interventions can include subsidies and the regulation of school environments.

South Africans consume high levels of salt in excess of the international guidelines (which recommend not more than 6 grammes per day for adults) (Puoane et al. 2013). In 2016, the government implemented legislation for mandatory maximum sodium levels to be observed

across a wide range of processed food categories, including processed meat, stock cubes, noodles and potato crisps (Charlton et al. 2021). A pre-mid-impact evaluation of the effectiveness of this legislation found that salt intake (measured using 24-hour sodium excretion) dropped by 1.16 grammes per day between 2015 and early 2019 (Charlton et al. 2021).

The government also implemented a number of other policies, including the prohibition of advertising to children and the insistence on the stricter labelling of food. In 2016, it became the first African country to introduce a tax on sugar (Puoane et al. 2013; Samodien et al. 2021). South Africa has, however, stalled on its efforts to develop and implement front-of-package labelling for nearly a decade (Gonzalez 2022).

Although the effectiveness of these policies is yet to be realised and some policies are yet to be implemented, it is commendable that NCD reduction through food policies is on the policy agenda. However, these policies do little to address the fact of socio-economic inequality in diet-related health (Samodien et al. 2021). The focus of the food policies is on food itself, and this does little to change the food environment or reduce inequalities at a deeper level. The existing policies offer little that directly address the problem of reducing socio-economic inequality in diet-related health issues.

Transforming South Africa's food system to an equitable one needs to be informed by equity-focused concerns. Friel et al. (2015: ii82) suggest that equity-focused approaches to promoting healthy diets in food systems should 'ideally consider actions that … reduce inequities in the immediate conditions in which people are born, live, work and play. [These should] also directly address food availability, accessibility and price in local food environments.'

South Africa's food-security strategy continues to be directed largely at increasing food production; but the real problem is food accessibility. While the country produces enough food to feed the entire population, the high unemployment rate means that many South African lack the financial means to access or purchase nutritious food.

The government needs to implement policies that increase the ability of the poor to access nutritious food (see discussion below). Despite notable gains in poverty reduction, poverty levels remain high amongst the black population (Plagerson 2021). Inequalities persist despite government efforts around social spending, targeted transfers and affirmative action and other initiatives to increase the distribution of wealth for black South Africans.

The transition to a more equitable food system requires solutions that improve the entire food environment and work to promote healthy diets. Swinburn et al. (2011) argue that policy interventions are more effective when directed at the context in which the making of healthy choices (affordable, accessible and desirable) takes place rather than allowing consumers to make the decision around healthy food choices to take place in an unhealthy food environment.

Lack of access to food could be improved by implementing a basic income grant to incorporate the unemployed (Greenberg 2015). The government needs to develop strategies that increase actual food access to the poor and subsidise healthy foods while taxing unhealthy foods to make them unattractive to consumers. The child grant should include a healthy food hamper, while school feeding programmes (SFPs) should serve as a means for poor, working class children to gain regular access to nutritious food.

**The government needs to develop strategies that increase actual food access to the poor and subsidise healthy foods while taxing unhealthy foods to make them unattractive to consumers.**

Indeed, South Africa's National School Nutrition Programme (NSNP) provides meals to more than 9 million poor school children. A recent study of the efficacy of the NSNP in the Eastern Cape Province 'suggests that school feeding interventions can improve children's nutritional status … and even protect against overweight and obesity … [while] the addition of breakfast as a second meal in school seems to reinforce these positive outcomes for children' (Devereux et al. 2018: 15).

While the South African government spends almost R7 billion annually on food for the NSNP (Mensah & Karriem 2021), the bulk of this is procured from Big Food and Beverage, with very little bought from small farmers, since the NSNP merely 'encourages' schools to buy fruits and vegetables grown locally.

> **The focus of the food policies is on food itself, and this does little to change the food environment or reduce inequalities at a deeper level.**

By contrast, the Brazilian government passed a law which legally compels schools to purchase a minimum of 30% of all agricultural produce for school feeding programmes from small farmers and land-reform beneficiaries. This new law in Brazil increased the supply of fresh fruits and vegetables to SFPs and restricted the procurement of products that were high in sodium, sugar and saturated fats at schools (Devereux et al. 2018; Mensah & Karriem 2021).

The South African government could learn from this example. It could use its R7 billion food procurement budget to reduce its dependence on Big Food and Beverage and support local food systems, thereby improving the livelihoods of small farmers, land reform beneficiaries, and urban gardeners.
In general, the government could play an important role in promoting and supporting local food systems through the procurement of nutritious food for SFPs and food-insecure communities, and thereby contribute to reducing the high prevalence of NCDs in South Africa.

Access to clean water and sanitation is also important to food safety. A multi-scalar approach to tackling food-system inequities needs to be adopted, an initiative which should include the government, farmers, retailers, marketers, and consumers. Government departments need to develop this kind of synergy if the state is to successfully address the increasing prevalence of NCDs.

## Conclusion

The prevalence of NCDs continues to increase in South Africa. It burdens South Africa's already beleaguered health-care system, which is already grappling with communicable diseases, ad hoc injuries and maternal and child mortality. It is now essential to realise that NCDs are caused by preventable risk factors, with the fact of unhealthy diets being one of the key drivers. Food insecurity, malnutrition, food waste and the increase of NCDs are manifestations of inequalities in South Africa's food system – inequalities which are rooted in socio-economic inequality and inequitable distribution of resources.

While the government has promoted food policies which aim at tacking NCDs, the gap between policy and practice needs to be bridged. Inequalities stubbornly persist, and there is a need for stakeholders to proactively address these and promote more equitable food systems. Food-system governance is necessary for recognising and monitoring the different actors within the food system in order to reduce food waste.
It is important to address all these challenges if we are to transform South Africa's food system into a more equitable and sustainable one, one which not only reduces food insecurity and NCDs, but which is also resilient in the face of future stresses and shocks, such as those experienced with COVID-19.

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FEATURE

# Unhealthy Food: The Beverage Industry's Digital Media Campaign to Stop the Approval of the Front-of-Package Labelling System in Mexico

*Claudia Nieto, Alejandra Aviles, Ana Munguía and Simón Barquera*

## Introduction

*The consumption of processed and ultra-processed foods is associated with various types of non-communicable diseases (NCDs), including cardiovascular diseases, breast cancer, and diabetes. Processed food products are usually made by adding salt, oil, and sugar as agents of preservation. These processes and their ingredients aim to increase the lifespan of foods, and also to make them more enjoyable by exaggerating or enhancing their taste.*

Ultra-processed foods make use of other ingredients, with these mainly the result of industrial processes. Generally speaking, processed and ultra-processed foods contain excess levels of energy and also nutrients of concern. These include sugar, salt, saturated fat, and trans-fat, all of which may pose a substantial public health concern due to overconsumption.

The front-of-package labelling (FOPL) system helps consumers by alerting them to the content-levels of damaging nutrients, thus enabling them to make healthier food choices at point of sale. This system displays black octagons on products that exceed the cutoff points for energy and/or nutrients of concern.

International organisations such as the World Health Organization (WHO) and Pan American Health Organization (PAHO) developed FOPL as a tool for guiding consumers towards a healthier diet. The PAHO advocates for the right to health and to information, noting that, in Mexico, warning labels are comprehensible to all, regardless of socio-economic status and educational level. As well as enforcing the right to information, a priority of the state should be alerting citizens to dangerous health outcomes that can arise from the regular consumption of processed and ultra-processed foods. The adoption of an FOPL system should be encouraged.

**The PAHO advocates for the right to health and to information, noting that, in Mexico, warning labels are comprehensible to all, regardless of socio-economic status and educational level.**

Indeed, in October 2019, the Mexican Congress established a mandatory labelling system in the General Health Law. This replaced the previous Guideline Daily Amount (GDA) statement to be found on processed and ultra-processed foods. This change was necessary because the GDA system faced several limitations. The

GDA statement gave information without context: that is, it provided no information on the recommended daily calorie intake for a healthy adult and did not distinguish between the needs of children and adults. Consumers would have to work all this out for themselves, without any guidance. Not surprisingly, evaluations of GDA showed that the information was difficult for students of nutrition (Stern et al. 2011), let alone the population in general (Nieto et al. 2019).

Civil society organisations provided public support to a change in the labelling system that would bring it into line with WHO and PAHO recommendations. After some years of public pressure (including vocal academic support) for improved regulation, the new system was approved in March 2020 as the Mexican Official Standard (*Norma Oficial Mexicana* (NOM)).

The approval process took from August 2019 to January 2020. This involved numerous meetings of working groups, and discussions with all the actors involved, including civil society organisations, academia, international organisations, government agencies and representatives from the food industry itself. These meetings were run by the Ministry of Economy and the Federal Commission for the Protection against Sanitary Risks (COFEPRIS). The first phase of the implementation of the new labelling system began in October 2020.

This kind of legislation does not favour commercial and financial interests. Similar legislation in other Latin American countries (such as Chile and Peru) was strongly resisted by these interests. In 2019, the World Cancer Research Fund International (WCRF) described the food industry's resistance to FOPL as the deployment of the 4Ds: delay, divide, deflect and deny.

In line with this strategy, throughout the consultation process in Mexico, strong opposition to changes to the existing labelling regulations was voiced by the food industry in the media (television, radio, both print and digital newspapers, as well as social media), and this opposition proved successful in at least delaying the passage of the new, tighter legislation on labelling.

This article will focus on the delaying tactics deployed by the food industry in digital media (including newspapers). We believe that documenting the Mexican experience can assist other countries in the design, approval, and implementation of new evidence-based policies. The intention is to show how the food industry's 4D tactics were used in digital media in Mexico as it sought to move towards a new system of FOPL.

## Methods

We made use of Google to conduct a search of internet and digital newspapers in the Spanish language from 2019 to 2022. In doing so, we distinguished between information available before and after the implementation of the new law in October 2020. The keywords used to conduct the search were *labelling, official Mexican act, and food industry* (in Spanish, *etiquetado, norma oficial Mexicana 051, and industria alimentaria).*

Two independent coders were asked to categorise the main arguments found in the media according to the four main types of counterargument (the 4Ds) described by the World Cancer Research Foundation analysis (WCRF 2019) – delay, divide, deflect, and deny – with a percentage agreement of 95.6%, while a third coder checked this categorisation for discrepancies. Discrepancies were examined and resolved in a discussion with the three coders after a collective Zoom session.

In addition, given the massive political and economic implications of the COVID-19 pandemic, we also searched for any arguments in favour of a delay in approving the new regulatory system arising from this, thus adding to our search the terms coronavirus, COVID-19, and pandemic.

**We believe that documenting the Mexican experience can assist other countries in the design, approval, and implementation of new evidence-based policies.**

**We used the following definitions in our general categorisation of the food industry's arguments:**

- Delay arguments included those in which the industry demanded a longer consultation period; pushed for the gathering of more research and evidence; or argued that the new regulation would be too difficult to implement administratively.

- Divide arguments included industry's various promises to develop and promote its own labelling (less stringent than the government's, and often confusing and difficult to interpret); direct attacks on the detail of the new labelling (e.g., on format and thresholds); as well as the direct lobbying with politicians behind closed doors aimed at stopping regulation.

- The deflect arguments included claims that warning labels are misleading and scared people; that regulation undermined individual responsibility; and that the government should not interfere with the people's right to make their own food choices. In addition, the arguments asserted that the nutrient-profile model was too strict, with the result that all foods would require warning labels; and that the proposed new labelling would restrict trade, damage the economy, and cause job losses.

- Finally, deny arguments insisted that there was neither enough evidence to support the new labelling scheme, nor any proof that the new scheme would be effective if adopted.

## Results

We found 46 digital media articles that mentioned at least one of the keywords. Table 1 shows the number of arguments found in each category and gives examples of quotes found.

Of these, 10 were delay arguments. These appealed to the concept of amparo legal (legal protection of rights) in requesting a delay in implementation on the grounds that re-labelling products takes time. The articles revealed common arguments where the industry pushed for longer consultation periods; pushed for the collation and consideration of more research and evidence; and argued that the new regulation would be too difficult to implement administratively and too costly financially.

Divide arguments insisted that the call for the new labelling is neither underpinned by scientific evidence, nor aligned with existing international trade practices. In addition, it is argued that small companies would not be able to keep up with the new norms; that such regulation would violate such legal rights as the right to intellectual property; and would have a negative effect on commerce.

Different elements of the labelling system were also criticised, notably that the proposed regulation does not allow comparison between products and does not differentiate between natural and added sugars. It was also found that the industry asked for less stringent labelling and proposed the implementation of a QR code to scan and make visible any product's nutritional information.

> **...it was widely claimed that the nutrient-profile model was too strict, and would result in the untenable situation of all foods being required to have warning labels.**

Deflection argued that the new warning labelling was confusing; that labels violate the right to information; actually provide less information to consumers; and would not, in any case, solve the health problem. We also found warnings that the labelling standard would result in damage to the industry as a whole and consequently to employment and to the economy; would involve violations of international trade agreements (such as United States-Mexico-Canada Agreement); and result in the creation of a 'black market' in food in the country.

In addition, some claimed that warning labels scare people and mislead them, while other arguments focused on the question of individual responsibility

and insisted that governments should not interfere with people's food choices because it violates their rights as consumers.

Furthermore, it was widely claimed that the nutrient-profile model was too strict, and would result in the untenable situation of all foods being required to have warning labels. (Denial arguments insisted there was no scientific evidence to substantiate the claims for the health benefits arising from improved labelling, and no evidence for their effectiveness.)

We found three arguments that used the deny tactic. They held that there was no scientific evidence about the impact of health benefits and no evidence about the effectiveness.

Finally, we also found five arguments that appealed to the COVID-19 pandemic as a reason for stopping the implementation of the labelling system. One industry chamber asked to stop the implementation of the warning label system, while the majority of chambers said that the situation was aggravated by the expenses and losses that came with the pandemic.

**Table 1.** Classification of arguments in the media challenging the Mexican warning label system (n=46)

| 4Ds | Number of arguments | Quotes from the media |
|---|---|---|
| Delay | 10 | **Quote 1:** '... initiated litigation in recent weeks because we believe that there are alleged violations of the right to information, the right to health and the way in which the process of the norm was carried out'<br><br>**Quote 2:** 'We trust that the final legal resolution of the authorities will protect the rights to information, health and nutrition of Mexicans'<br><br>**Quote 3:** 'NOM-051 must be discussed again to put the consumer first and the social cost that the norm will have'<br><br>**Quote 4:** 'The Court ... granted the provisional suspension of the development of the NOM-051, for which its publication and entry into force for the moment is stopped' |
| Divide | 3 | **Quote 1:** 'The new labelling does not allow comparison between different pre-packaged products'<br><br>**Quote 2:** 'Warning labelling does not differentiate between the sugars that are naturally present in a product and those that were added in its elaboration'<br><br>**Quote 3:** In order to have more information, 'an alternative is to put electronic codes (like QR) instead of the front-of-pack warning labels' |

| 4Ds | Number of arguments | Quotes from the media |
|---|---|---|
| Deflect | 30 | **Quote 1:** 'Lack of solidarity from the health authorities in the midst of a pandemic'<br><br>**Quote 2:** 'It will affect the economy, industry, commerce, services and employment'<br><br>**Quote 3:** 'We will have lower income and job losses'<br><br>**Quote 4:** 'The policy will generate a black market'<br><br>**Quote 5:** 'An unnecessary interference'<br><br>**Quote 6:** 'It clearly violates agreements such as the T-MEC'<br><br>**Quote 7:** 'A healthier population will be achieved with better nutrition, adequate serving sizes and exercise'<br><br>**Quote 8:** 'There is an inventory of 5 million products with a value of 20 billion pesos that are already labeled, and it is practically impossible to sell them in two months'<br><br>**Quote 9:** Short period of implementation: 'More than five million products could be destroyed'<br><br>**Quote 10:** 'Without considering the cost of the intellectual property of the brands, it will cost 6 billion pesos to make changes to the packaging'<br><br>**Quote 11:** 'It will cost the sector more than 270 million dollars to change the labelling of products'<br><br>**Quote 12:** 'We cannot discriminate any type of product ... we need dietary orientation and physical activity' |
| Deny | 3 | **Quote 1:** '[T]he consumption of sugar products may not be the true solution to the serious public health problem of diabetes and obesity'<br><br>**Quote 2:** 'We are in a campaign against sugar; it has been stigmatised for considering it guilty of obesity, diabetes, when other factors contribute to that'<br><br>**Quote 3:** 'Businesses and consumers will be affected because the technical-scientific evidence, the cost-benefit of the measure, the impact on free competition, respect for international treaties, the rights of consumers to access truthful and clear information ... [were] not rigorously [analysed]' |

| 4Ds | Number of arguments | Quotes from the media |
|---|---|---|
| Use of COVID-19 pandemic | 5 | **Quote 1:** 'The Mexican industry was affected by the coronavirus'<br><br>**Quote 2:** 'Due to Covid-19 it is onerous to implement and comply with the date for the entry into force of the new labelling'<br><br>**Quote 3:** 'We request that in the face of the COVID-19 emergency and the still unknown economic and social impact, NOM-051 not be published'<br><br>**Quote 4:** 'This year was complicated by COVID-19, and the Mexican beverage and processed food industry is having trouble complying with the front labelling of its products'<br><br>**Quote 5:** 'We need to postpone measures such as the labelling that will be applied to food and beverages for at least three years, because these requirements can complicate supply in the midst of the health emergency due to COVID-19' |

**All quotes were transliterated from Spanish to English**

# Discussion

Our study found that the food industry used a variety of tactics to delay implementation of the new FOPL regulation. Of the five tactics analysed – delay, divide, deflect, deny, and COVID-19 – industry relied the most on deflection. Deflection sought to generate fear and doubt among the population about the possible adverse effects on the economy and on employment of the new legislation.

We also found that the food industry tried to delay implementation through litigation and recurso de amparo (appeal for protection under a constitutional right). Amparo allows for the protection of a human right over and above other laws and regulations. A successful appeal on the grounds of amparo would mean that the food industry could refuse the NOM-051 regulation.

To claim amparo, it contended that 'there were violations of the right to information, the right to health, and the way in which the process of the Standard was carried out'. Industry questioned the validity of the strategy on the grounds that no decline in obesity had been recorded in countries where the strategy had been implemented (using the example of Chile).

To date, we have noted more than 50 recurso de amparo filed by food and beverage companies seeking to avoid regulation (Forbes, 2020).

Similar tactics have been observed in other Latin American countries. When the Chilean government implemented a food-policy package designed to help prevent NCDs and included the regulation of marketing to children, school retail, and FOPL in this, the food and beverage Industry responded by expressing concern

about the impact the regulations would have on market outcomes (Corvalán et al. 2014). In fact, studies found that employment and average real wages were not affected by the new regulations (Paraje et al. 2022).

> **'States must also address childhood obesity and limit children's exposure to foods high in fat, sugar or salt, and to beverages high in caffeine or other substances with possible harmful effects'.**

Similarly, the food industry's claim that it was 'unaware' of the consultations around the new labelling legislation in Mexico was found to be erroneous by UNICEF: industry representatives were present at more than 20 of the consultative meetings, and in fact submitted comments on the draft proposal. The NOM-051 consultation process was both democratic and transparent, one in which saw voluntary participation by all interested sectors, including the food industry. Other results in the UNICEF report, such as questioning the scientific evidence and affirming commitment to promoting healthy diets (Munguia et al. 2021), are in line with the ones found in this case study.

The food industry also tried to use the COVID-19 pandemic as a reason for delaying implementation of the new warning labelling system. Alleging a negative impact on the private sector, it requested a three-year extension. However, following the approval of the regulation, it was only able to obtain two smaller extensions. The first of these was for two months (to avoid sanctions on products that did not display the warning labels), and the second, also for two months (to incorporate a number of requirements, including updating nutritional information).

The nutrition-profile model implemented with the warning labelling system is fully supported by scientific evidence. The Mexican model was based on the cutoff points established by PAHO, following rigorous standards of scientific evidence. The arguments by the food industries seeking to undermine this evidence simply cannot be taken seriously. Details about the approval process and the evidence behind the decision are publicly available.

With regard to human rights, it is essential to consider the nature of the rights of children. Here, the state has the obligation to ensure protection for the best interests of the child, including the right to health. According to Trade-Related Aspects of Intellectual Property Rights (TRIPS 1994), there has to be flexibility regarding regulations concerned with public health interests: public health concerns prevail over commercial interests.

In addition, the Committee on the Rights of the Child, in General Comment No. 15, states that the child has the right to enjoy the highest possible level of health (article 24), and stipulates that 'States must also address childhood obesity and limit children's exposure to foods high in fat, sugar or salt, and to beverages high in caffeine or other substances with possible harmful effects'.

This case-study deals only with internet-based media; it does not include television or radio. Analysis of them is very likely to reveal an even greater number of attempts to impede the approval and implementation of the new warning labelling system in Mexico. In addition, certain media have the tendency to defend or attack the food and beverage chambers, due to their deals, and businesses, or due to shared ownership or competition with other companies, so the current results are to be interpreted as necessarily partial rather than complete in terms of total media coverage.

> **Analysis of them is very likely to reveal an even greater number of attempts to impede the approval and implementation of the new warning labelling system in Mexico.**

## Conclusion

The food and beverage industry consistently made use of false rather than evidence-based arguments to delay, divide, deflect, and deny the implementation of the new FOPL system. It has done so despite the fact that this system has proved to be effective in reducing over-consumption of critical nutrients.

The most prevalent tactic was deflection. Various counterarguments were put forward: the threat to the economy; blaming the individual rather than considering the reality of the obesogenic environment (understood as the sum of influences that the surroundings, opportunities, and conditions of life have on promoting obesity in individuals or populations). The repeated appeal to COVID-19 also shows the industry's willingness to use a variety of tactics to challenge the approval and implementation process.

Our hope is that the information and analysis provided in this document can help key actors and stakeholders both anticipate and address the likely pushback by the food industry during the public processes involved in the approval of healthy food policy regulations.

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FEATURE

# Some Legal Issues around the Adoption of Simplified Nutrition Labelling in South Africa: An Analysis of Draft Regulation R429

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## Introduction

*Non-communicable diseases (NCDs), specifically diet-related non-communicable diseases such as diabetes and cardiovascular disease, are a growing problem in South Africa (Nojilana et al. 2016; Shisana et al. 2014). These diseases share a number of risk factors, including being obese or overweight and consuming unhealthy foods high in saturated fat, salt and sugar.*

Given the fact of these shared risk factors, many NCDs can be prevented by improving the healthiness of diets. Many of the recommended interventions for the prevention of NCDs are already legal and form part of the regulatory regimes of numerous countries (Magnusson & Patterson 2014). South Africa has adopted many of these interventions, including restrictions on sodium (salt) in foods, banning trans-fats and imposing a tax on sugary beverages (Ndinda et al. 2018). However, further action is necessary if we are to prevent NCDs and protect the health of South African citizens.

There is a growing consensus that the provision of simplified nutrition labels is an effective obesity-prevention tool (Dereń et al. 2021; Riis et al. 2015). Though many countries have some form of nutrition-labelling on food items, consumers often have difficulty understanding and processing the given information, thus struggling to make informed decisions about food purchases.

The provision of simplified nutrition labels can improve consumers' awareness of how healthy or unhealthy particular food products are and assist them in making informed purchases (Dereń et al. 2021; Riis et al. 2015). As a result, many governments are introducing simplified nutrition-labelling schemes, such as mandatory front-of-package labels (FOPL). Currently, more than 10 countries (including Chile, Peru and Uruguay) have adopted mandatory FOPL regulations (Jones et al. 2019).

Many agree that these measures also play a critical role in the realisation of socio-economic rights. In 2020, the then United Nations Special Rapporteur on the right to health, Dainius Pūras, issued a statement (endorsed by Michael Fakhri, the Special Rapporteur on the right to food) noting that FOPL (specifically warning labels) were fully in accord with state obligations in regard to the right to health:

**...simplified nutrition labels can improve consumers' awareness of how healthy or unhealthy particular food products are and assist them in making informed purchases .**

> [NCDs] are a major challenge of this century highly rooted on overweight, obesity and unhealthy diets. As part of their right-to-health duties, States should address the diet-related NCDs' preventable risk factors and promote frameworks whereby the food and beverage industry convey accurate, easily understandable, transparent and comprehensible information on their products. Front-of-package warning labelling regulations are much needed in this regard (Pūras, 2020).

In this article, we consider the role of South Africa's constitutional and regulatory frameworks in the adoption of simplified nutrition labelling. Specifically, we assess the opportunities for and barriers to this as they stand in the existing legal system. We begin by outlining the relationship between human rights and diet-related-NCDs (DR-NCDs) under international human rights law and the South African Constitution (1996). We then look at the regulatory and legislative framework related to labelling and consider whether South Africa's draft FOPL regulations satisfy the mandate to implement FOPL under the right to health.

## The rights-based rationale for simplified nutrition labelling

The right to health is recognised by a number of international treaties and conventions. In 1946, the right to the 'highest attainable standard of living' was recognised in the World Health Organization's constitution (1946). Two years later, in the Universal Declaration of Human Rights, the 'right to a standard of living adequate for the health and well-being' of all people was recognised in article 25. In 1966, the International Covenant on Economic, Social and Cultural Rights stated that everyone is entitled to the 'enjoyment of the highest attainable standard of physical and mental health'. Regionally, the African Charter on Human and Peoples' Rights (the African Charter) recognises that every individual has the right to 'enjoy the best attainable state of physical and mental health'.

In many instances, these documents also recognise a right to food as an underlying determinant of the right to health, as a component of the right to life, or as its own self-standing right. As Pūras (2020) noted in his statement,

> [t]he 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.

Although the African Charter does not expressly recognise a right to food, the African Commission on Human and Peoples' Rights (the Commission) states that the right to food is implicitly recognised in the right to life and right to health. More directly, in Social and Economic Rights Action Center and another v Nig, the Commission noted that

> [w]hile 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.

The Commission has also identified a clear link between the right to health (and other rights) and access to nutritious food, stating in a 2019 resolution that it is 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'.

**...to the underlying determinants of health, such as an adequate supply of safe food and nutrition.**

The Commission (2019) called on State Parties '[to t] ake 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'.

> **Obesity and related health conditions place a significant burden on the health-care system...**

This injunction is relevant to the South African context as the Constitution (1996) does not contain a right to health per se, but rather a set of entitlements which, when taken together, may provide an entitlement to health. Section 27(1) encapsulates these in the socio-economic rights of access to health care, food, water and social security. In addition, the constitutional mandate to consider international law when interpreting the Bill of Rights (section 39(1)(b)) strengthens the link between the right to health, the right to food, and access to nutritious, quality food.

Given these provisions, the adoption of an FOPL system to prevent obesity can find support within section 27, particularly so with regard to the right of access to sufficient food in section 27(1)(b). In addition, the significant burden that NCDs place on the health-care sector could support the view that the COVID-19 epidemic and corresponding prevention efforts have an indirect impact on the right to access to health-care services provided in section 27(1)(a).

Section 7 of the Constitution places obligations on the state to respect, protect, promote and fulfil all these rights. The adoption of measures that simplify labelling and improve consumer understanding of the nutritional content of food can promote and fulfil the right to food by enabling consumers to make informed decisions about their nutrition and their access to properly nutritional food. Obesity and related health conditions place a significant burden on the health-care system, and consequently, any measures aimed at NCD prevention also serve to protect the broader community's right of access to health care.

Patterson et al. (2019) have argued that a rights-based approach to preventing NCDs may bring into play a number of other civil and political rights, many of which have been codified in the South African Constitution (such as the rights to life and bodily integrity). In addition, FOPL systems can be understood in terms of the realisation of the right to information, or may even negatively impact the right to freedom of speech vis-à-vis commercial speech.

Despite the complexity of the interaction between these rights, there is a clear basis on which one can find support for action on NCDs (specifically the introduction of a FOPL system) within the Bill of Rights.

## Frameworks for adopting FOPL

South Africa has a number of laws which regulate labelling. These include the Consumer Protection Act 68 of 2008 (the CPA); the Agricultural Product Standards Act 119 of 1990 (APSA); and the Foodstuffs, Cosmetics and Disinfectants Act 54 of 1972 (the Foodstuffs Act).

The Consumer Protection Act (CPA) is broadly relevant to the introduction of FOPL systems and, in certain respects, provides support for their adoption, as one of the stated goals of the CPA is to provide consumers with accurate information in plain language.

Specifically, the purpose of the Act, as outlined in section 3, is that the CPA aims to advance the welfare of consumers whose ability to comprehend labels may be limited. In section 22, the CPA provides that a consumer is entitled to information of a kind whose 'content, significance and import' the 'ordinary consumer ... with average literacy skills and minimal experience as a consumer of the relevant goods or services, could be expected to understand'.

The CPA contains several other provisions that support the introduction of a simplified FOPL. There is a prohibition of marketing which is misleading or deceptive in any way as to the nature and properties

of goods (section 2), and a warning against failure to disclose relevant material facts to the consumer, including the disclosure of ingredients and qualities of goods (section 41). The CPA also mandates warning labels for goods that are hazardous or unsafe (section 58) (although this definition does not currently encompass unhealthy foods as risk factors for NCDs).

The Foodstuffs Cosmetics and Disinfectants Act 54 is the primary legislation concerned with the labelling of food items and products as well as the regulation of food composition. NCD prevention measures (such as the placing of limits on the amount of trans-fats and sodium in certain foodstuffs) were enacted through regulations under the Foodstuffs Act. Section 15 of the Foodstuffs Act empowers the Minister to make regulations 'prescribing, prohibiting, restricting or otherwise regulating [...] labelling [...] of any foodstuff'. At present, the regulations relating to the Labelling and Advertising of Foodstuffs (R146 of 2010) require that food items carry a back panel containing the nutritional information, and set parameters for any health or nutritional claims carried on food items.

The Agricultural Product Standards Act (APSA) has also been used to introduce labelling requirements that complement the nutritional labelling system prescribed under the Foodstuffs Act. Thus, the Fruit Juice Regulations R286 of 1980 determine that items are required to carry a country-of-origin label; prescribe the requirements for labelling a beverage as a fruit juice blend; and outline how ingredients should be disclosed on the nutrition label required by R146.

In 2014, the National Department of Health (NDOH) published a draft of Regulations Relating to the Labelling and Advertising of Foods: Amendment R429 of 2014 (R429). The draft R429 sought to introduce a voluntary FOPL scheme specifically to address NCDs, as evidenced by the definition of FOPL, which entails an emphasis on 'certain nutritional information associated with the risk of developing and contributing to non-communicable diseases, outside of the Table with Nutritional information' (NDOH 2014).

The FOPL scheme outlined in R429 is not a warning-label scheme such as that endorsed by Pūras (2020) and adopted in other countries. Instead, it utilises a voluntary traffic-light type system whereby the key nutrients of energy, sugar, fat, saturated fat and sodium are given a red, green or yellow indicator, according to the healthfulness of the ingredients.

## Does R429 meet the human rights imperative to prevent NCDs?

There are some significant differences between the labelling systems proposed in R429 and the FOPL warning system endorsed by Pūras (2020). The key question is whether the adoption of a voluntary traffic-light system would suffice to meet South Africa's human rights obligations.

> **The key question is whether the adoption of a voluntary traffic-light system would suffice to meet South Africa's human rights obligations.**

The answer hinges, most significantly, on whether the R429 can meet the stated purpose of reducing DR-NCDs by enabling consumers to identify unhealthy and healthy foods. Jones et al. (2019) propose a framework to evaluate FOPL systems as a regulatory public health intervention (Table 1). The framework is useful in assessing FOPL systems because it is designed for a legal assessment and can be used to identify areas where improvement is necessary.

Following this framework, we have evaluated the draft R429 in three key domains: regulatory form, regulatory substance, and regulatory governance. The high-level findings are outlined in Table 1, with a more detailed discussion given below.

**Table 1:** An analysis of R429 utilising a framework for improving FOPL regulations

| Component | Summarised application to FOP nutrition labelling as outlined by Jones et al. (2019) | Adequacy indicator | Quotes from the media |
|---|---|---|---|
| **Domain one: Regulatory form** | | | |
| Regulatory framework | Governments should consider mandatory legal frameworks to overcome sub-optimal voluntary uptake. | ⊗ | Draft R429 is a voluntary FOPL despite the fact that the provisions of the Foodstuffs Act allow for the introduction of a mandatory FOPL system. |
| FOP nutrition-label format selection | The FOP nutrition-label format should be interpretive. Formats indicating unhealthfulness seem more effective in guiding consumers to nutritionally favourable products. | ○ | Draft R429 utilises a simple traffic-light system. Evidence from high-income settings indicates that these may be effective, but evidence from low-income settings indicates that a warning-label system is easier for consumers to understand, particularly where there are low levels of literacy |
| **Domain two: Regulatory substance** | | | |
| Regulatory objective(s)<br><br>Operative terms and conditions | The aim of FOP nutrition labelling is to inform and guide consumers towards healthier food choices; a secondary aim is to stimulate the production of healthier foods by the industry. | ⊗ | The voluntary nature of draft R429 reduces its efficacy at achieving these objectives. Companies with unhealthy products can choose not to use the label rather than reformulate or discourage consumers from purchasing their products. |
| Policy coherence | Operative terms include display specifications that promote visibility and salience; nutrients and food components included that link to health evidence; valid scoring criteria and reference amount; justified scope. | ○ | Draft R429 does contain a nutrient profiling model to use in determining the healthfulness of food products; it also excludes certain products from its scope. However, R429 does not prescribe display specifications beyond colour. The evidentiary basis for the regulation is unclear. |
| | FOP nutrition labelling should be aligned with, and enhance the operation of, other national health and nutrition policies, food regulations and relevant WHO and Codex guidance. | ✓ | A FOPL system would enhance existing laws and public health initiatives. South Africa has existing interventions related to some key nutrients, as well as consumer protection legislation that seeks to improve the comprehensibility of labels. |

| Component | Summarised application to FOP nutrition labelling as outlined by Jones et al. (2019) | Adequacy indicator | Quotes from the media |
|---|---|---|---|
| **Domain three: Regulatory governance** | | | |
| Drafting regulatory rules and scheme design | Government retains ultimate responsibility and authority for setting regulatory objectives and scope. Information should be transparent and easily accessible. There should be appropriate safeguards for managing conflicts of interest. | ○ | R429 was open to public comment, but it is unclear what resulted. The consultation that gave rise to the draft, the submissions, and the issue of whether appropriate systems are in place for managing conflicts of interest are unclear, particularly given industry involvement in other regulations such as sodium restrictions. |
| Administration | Administration is granted to an independent statutory authority, government body or multi-stakeholder group with appropriate safeguards for managing conflicts of interest. The administrative body must be provided with requisite authority and resources to conduct monitoring and enforcement activities and to publicise performance outcomes. | ✓ | Administration of the regulations will sit with the NDOH, which has previously administered other labelling and NCD prevention regulations. |
| Monitoring | Baseline and follow-up data to be collected on uptake and label compliance by industry; consumer understanding and use; product purchases; population dietary intakes; and nutrient composition of foods. | ⊖ | It is unclear whether monitoring has occurred. |
| Evaluation | Government-led and/or carried out by independent body or research group with authority to assess achievement of the regulatory objectives using a transparent framework and sufficient data to assess whether performance indicators are met in the specified timeframes. | ⊖ | It is unclear whether evaluation has occurred. |
| Enforcement | Enforcement may be supported by pre-market approval. The administrative body possesses a range of sanctions, including positive and negative publicity, written requests for action, withdrawal of right to use (positive) labels, fines or legal action under new or existing law. | ✗ | Non-compliance with the regulation is an offence under the regulation but the voluntary nature of the regulation makes enforcement unlikely. |

**Source:** Adapted from Jones et al. (2019)

*Key for adequacy indicator, which indicates adequacy of R429 against the Jones et al. framework: ✓: Adequate; X: Inadequate; O: Adequacy uncertain; -: Needs more information)*

## Regulatory form

Right from the start, the voluntary nature of R429 severely compromises its ability to achieve any public health or other purpose since implementation cannot be enforced. A WHO review of FOPL systems in Europe demonstrated that voluntary labelling schemes have little uptake and do little to inform consumers about the unhealthiness (or not) of a product (Kelly & Jewell 2018). Voluntary measures are unlikely to achieve regulatory objectives.

In addition, it is questionable whether the traffic-light format adopted by R429 is 'most understandable to all population subgroups' (Jones et al. 2019): formats which directly indicate the unhealthfulness of a product are much more effective. While there is evidence that shows the traffic-light format can be effective in high-income (and high-literacy) countries such as Australia and New Zealand (Dodds et al. 2014; White & Signal 2012), evidence from low- and middle-income countries reveals that the traffic light can be confusing for some consumers and that warning labels may be more effective (Freire et al. 2017; Khandpur et al. 2018; Talati et al. 2016).

There is currently a need for evidence as to the kind of labelling system that would be most effective in South Africa.

## Regulatory substance

As mentioned, the voluntary nature of R429 reduces its likelihood of achieving the objectives of consumer guidance (steering consumers away from unhealthy products and towards healthier ones, as well as trying to incentivise reformulation): companies with unhealthy products can simply choose not to label. Apart from prescribing the colour scheme, R429 offers little in the way of design specifications for FOPL. This results in inconsistent placement of labels, and, often, a reduction in effective invisibility.

Nonetheless, the broader policy and regulatory environment supports the adoption of FOPL. There are existing regulations that require the disclosure of nutritional information for foodstuffs; in addition, there is some supportive legislation, in the form of the CPA, that aims to improve consumer comprehension of labelling.

## Regulatory governance

It is difficult to assess how the governance components of the regulation have worked in the six years since R429 was promulgated, seeing as little information has been made public. Comparative research on the adoption of sodium restrictions on South African food products revealed that industry actors were given early access to the terms of the regulation and were able to exert their influence to weaken it (Kaldor et al. 2019).

All in all, there is a worrying lack of transparency about the governance process, and many of its working parts remain unknown. However, the fact that the administration of the regulation has been placed in the hands of the NDOH is a positive sign, given the department's considerable experience in the administration of other regulations of this kind.

## Recommendations

We find three key limitations in the FOPL system proposed in R429 (and note that these threaten to compromise its ability to effectively guide consumers towards healthier food choices).

- The first is the voluntary nature of the regulation, which actively undermines the possibility of both enforcement and evaluation.
- The second is the lack of clarity as to whether the format that has been adopted is evidence-based and likely to be effective in the South African context.
- The third major concern is that the process of formulating the regulation and FOPL system has lacked transparency and thus threatens to be susceptible to conflicts of interest and influences that have the potential to weaken and undermine it.

These three limitations also fall short of the recommendations from Pūras (2019) regarding the implementation of an FOPL system which is compliant with human rights:

> Within the framework of the right-to-health, States are required to adopt regulatory measures aimed at tackling NCDs, such as front-of-package warning labelling on foods and beverages containing excessive amounts of critical nutrients. Front-of-package warning labelling should follow the best available evidence free from conflicts of interest, as a mechanism through which healthy choices can become the easier and preferred option.

The limitations we have identified in the draft R429 FOPL weaken the regulation's usefulness in the task of enabling the South African government to meet its constitutional obligations to prevent NCDs. To ensure that the FOPL labelling system adopted in South Africa complies with both human rights and constitutional obligations, the government needs to ensure the efficacy of the regulation.

This requires that the policy must be evidence-based and responsive to context; that its format be legible to South African consumer across the divides of class and culture; that the government makes the adoption of FOPL mandatory; and that it put in place a clear monitoring and evaluation framework, one which is developed transparently and can be independent of the vested interests that will seek to weaken the regulation and, in doing so, compromise public health.

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FEATURE

# The National Strategic Plan for the Prevention and Control of NCDs 2022–2027: Assessing Policy Priorities to Address Unhealthy Diets

*Paula Knipe, Aisosa Jennifer Omoruyi and Ebenezer Durojaye*

*South Africa is a largely unequal society, one in which the legacy of apartheid remains visible in lack of access to healthy and nutritious food. Inequality has exacerbated the problems of access to nutritious food, problems which are amplified by actors such as the food industry itself. At present, the prevalence of diet-related non-communicable diseases (NCDs) is worryingly high, accounting for 51% of the country's annual deaths (WHO 2018).*

Unless the relevant preventative measures are taken, the burden of NCDs is predicted to increase substantially over the next decade (SMRC 2018). As things stand, obesity, high blood pressure and high blood glucose are responsible for the highest number of deaths and disabilities (Institute for Health Metrics and Evaluation 2021).

The metabolic risks for developing NCDs can be linked in large to the fact of unhealthy diets. These involve the excessive consumption of processed and ultra-processed foods which are high in sodium, fat, sugar, and which are also energy-dense and micronutrient-poor.

The prevalence of unhealthy dietary patterns can be attributed to a complex web of environmental and systemic drivers. These include food insecurity (FAO 2021); an unhealthy food environment (Igumbor E et al. 2012); and the failure to prioritise healthy nutrition in government initiatives aimed at addressing food insecurity (Spires M et al. 2016).

The increasing incidence of NCDs has been described as the result of a global economic system in which health comes second to wealth creation. The food industry is exemplary in this regard (Kickbusch, Allen & Franz 2016). The rise in diet-related NCDs can in large part be attributed to the commercial determinants of health, that is, it is the direct product of the corporate activities of the food industry in promoting food products and choices that are detrimental to health. The increasing consumption of unhealthy products is made possible by the wide availability, affordability, palatability and convenience of unhealthy processed foods (Puras 2020).

It is, that is to say, the product of the intense marketing strategies deployed by the food industry (advertising, sponsorships, and promotions), as well as of the growth

**“ The increasing consumption of unhealthy products is made possible by the wide availability, affordability, palatability and convenience of unhealthy processed foods**

and development of extensive supply chains that magnify the negative health impact of the processed food industry (Kickbusch, Allen & Franz 2016).

Not surprisingly, the food and beverage industry stands in opposition to nutrition-related health policies and fiscal interventions, while actively engaging in corporate social activities that seek to mask its bad reputation (Claasen, Van der Hoeven & Covic 2016).

The prevention of diet-related NCDs by ensuring access to adequate nutritious food is a public health and human rights challenge. Addressing this challenge requires high-level political commitment. The government needs to take a holistic approach to the problem of unhealthy food consumption patterns, and the proper regulation of the food industry forms a necessary part of this.

Simply expecting self-regulation from an industry which actively profits by damaging public health is not enough. Rather, what is needed are legal, policy and fiscal measures to curtail the activities of a food industry that works to influence the availability and consumption of unhealthy foods and drinks (WHO 2013; WHO 2015).

There is evidence for the effectiveness of upstream regulation of the food industry in improving the nutritional quality of the food supply as part of a broader government food and nutrition strategy (Mozaffarian D, 2018). Aspects of this strategy include placing limits on the salt and trans-fat content of processed foods; setting standards on labelling and advertising; and adopting a variety of fiscal measures, such as taxation of sugar-sweetened beverages (WHO 2017).

These measures are recommended in the WHO guidelines on priority and cost-effective interventions for low- and middle-income (LMIC) countries for the prevention of NCDs (WHO 2017). It is estimated that South Africa could save 67,000 lives by 2025 by implementing the WHO recommendations for controlling unhealthy diet and reducing the consumption of salt, sugar and fat (WHO 2018).

South Africa has taken a number of steps to respond to diet-related NCDs, partly under the influence of various international commitments. A key initiative was the South African Declaration on the Prevention and Control of Noncommunicable Diseases in 2011. This was an outcome of the South African Summit on the Prevention and Control of Non-Communicable Diseases held in Gauteng from 12–13 September 2011, hosted by the Minister of Health.

The summit was prompted by the growing mortality and burden of NCDs in South Africa, and aimed at creating partnerships between the National Department of Health and key stakeholders to develop comprehensive and intersectoral interventions.

**Not surprisingly, the food and beverage industry stands in opposition to nutrition-related health policies and fiscal interventions,**

In terms of prevention, the declaration makes a commitment to evidence-based interventions. These include using the WHO framework to address risk factors (and notably its Global Strategy on Diet, Physical Activity and Health) and improving the quality of food available to South Africans by means of intersectoral collaboration.

The main goals are, by 2020: to reduce the relative premature mortality rate (i.e., deaths under 60 years of age) by at least 25%; to lower the mean population intake of salt to less than 5 grammes per day; to reduce the number of obese and/or overweight people by 10%; and to reduce the prevalence of people with raised blood pressure by 20% through lifestyle and medication.

The targets of this declaration informed the objectives set in the National Strategic plan for the Prevention and Control of NCDs 2013–2017 (NSP 2013–2017) and set the stage for other legal and policy measures for addressing diet-related NCDs in South Africa. Following

the expiration of the NSP 2013–2017, the National Strategic Plan for the Prevention and Control of Non-Communicable Diseases 2022–2027 (NSP 2022–2027) was recently approved by the Department of Health.

In this article we assess the objectives of the NSP 2022–2027 in terms of addressing unhealthy diets in comparison with clinical prevention. A comparison is also made with the NSP 2013–2017 in terms of targets aimed at regulating the food environment in a bid to highlight shortcoming in the policy priorities of the new NSP. In doing so, we compare the targets and strategies of both NSPs with the aim of assessing the extent to which progress made under the preceding NSP influences the new NSP.

## The NSP 2022–2027

The recent strategic plan provides directives on the actions to be undertaken between 2022 and 2027 across health and other sectors to address and reverse the growing threat posed by NCDs in South Africa. A key feature of the new NSP is to ensure that such actions are defined and implemented so as to achieve Sustainable Development Goal (SDG) 3.4 by 2030 (this aims to reduce by one-third premature death and disability from NCDs through prevention and treatment, as well as promoting mental health and well-being).

The policy objectives are guided by human rights principles, equity, universal health coverage, integration, a life-course approach, and engagement with, and empowerment of, people and their communities.

This strategic plan is aligned with the global approach used to target the five major groups of NCDs (cardiovascular diseases; cancer; chronic respiratory disease; diabetes; and mental health, including neurological conditions), as together these are the largest contributors to NCD morbidity and mortality rates.

The plan also draws insight from the several UN and WHO guidelines which seek to achieve comprehensive prevention and control of NCDs through a multisectoral approach. As such, South Africa's policy emphasises the importance of combining 'health-in-all-policies' (HiAP), 'whole-of-government' and 'whole-of-society' approaches to address the threat of NCDs.

Goal 1 aims to raise the profile of NCDs as a priority group in need of prevention and control, and calls for the gathering of the data necessary for resourcing equitable and cost-effective interventions. The NSP states that Goal 2 aims to promote and enable health and wellness across the life course. This requires the engagement of non-health sectors and non-state actors to address the social and commercial determinants of health and behaviour change needed to tackle the five major shared and modifiable risk factors (NSP 2022–2027 vii).

Similarly, Goals 3,4 and 5 highlight the importance of strengthening the capacity of individuals and populations to adopt healthier behaviours and lifestyles. Here, the NSP 2022–2027 emphasises the role and mandate of the national, provincial and district health departments in implementing this strategy alongside a range of other partners and stakeholders (NSP 2022–2017 viii).

While the strategies for intervention at a primary level target the general population, with particular regard to unhealthy diet, the plan seeks to promote healthy nutrition in certain prioritised settings (such as workplaces, schools, and early childhood development centres (ECDs)), as well as support healthy food options in public institutions. The plan also aims to provide regular screening for, and promote awareness of, obesity in both adults and children.

> **...requires the engagement of non-health sectors and non-state actors to address the social and commercial determinants of health...**

There are, however, no clear or measurable targets or objectives for improving the food environment as a whole as a major driver of unhealthy diet, albeit that the plan does set clear targets regarding the clinical

prevention of certain NCDS. Goal 3 aims to improve people-centred services for the prevention and control NCDs. The NSP targets a 90/60/50 care model to be applied to blood pressure and glucose levels as a first step to improving early detection and treatment.

This cascading approach draws from lessons learnt from the care model adopted in South Africa's response to the HIV/AIDS crisis. A target is set to ensure that, by 2030, 90% of people over the age of 18 will know whether they have hypertension and/or raised blood glucose; 60% of people with raised blood pressure or blood glucose will receive intervention; and 50% of people receiving interventions will be monitored. For the duration of this NSP, evidence and data will also be gathered to support and analyse this care model, with a view to learning from it and applying its lessons to other NCDs.

While the 2013–2017 NSP set concrete goals and targets for addressing diet-related NCDs (especially in relation to obesity and salt content in food), the recent strategic plan lacks clear targets for addressing unhealthy diet as a risk factor, although it does set these with regard to clinical prevention and control.

## NSP 2013–2017

As mentioned, the NSP 2013–2017 drew from the targets set in the Declaration on the Prevention and Control of Noncommunicable Diseases (2011) and so set the stage for other legal and policy measures for addressing diet-related NCDs in South Africa. The policy had 10 targets, which were focused on both prevention and treatment of NCDs. Various measures were taken in regard to clinical prevention.

The policy targeted a 20% reduction in the prevalence of people with raised blood pressure by 2020 (through lifestyle and medication). It directed that every woman should be screened three times for cervical cancer in her lifetime (as was the practice with HIV-positive women), while every woman with an STD should be screened for cervical cancer every five years. In addition, the number of people tested for mental disorders should be increased by 30% (NSP 2013–2017 37).

> **"...the drive to ensure a healthy diet in South Africa needs to include cost-effective measures...**

A number of the policy's targets focused on diet-related risks. By 2020, the policy sought a reduction in the mean intake of salt to less than 5 grammes per day; a 10%-reduction in the obesity/overweight category; and a 20%-reduction in the number of people suffering from high blood pressure (through a combination of lifestyle and medication) (NSP 2013–2017 33).

The policy drew its measures from the global framework on the prevention of diet-related risk factors for NCDs. It acknowledged that the drive to ensure a healthy diet in South Africa needs to include cost-effective measures such as taxes, amendments to food labelling and advertising regulations, and public campaigns (NSP 2013–2017 37).

The policy noted that the key dietary changes needed in South Africa include a decrease in the consumption of salt, of all fatty foods, of snacks, sugary foods and drinks, and an increase in the consumption of lean proteins and low-fat dairy products, whole grains, legumes, fruits, and vegetables. Achieving this would mean sensitising all role-players (including government departments, NGOs, food producers and the public) to the need for this; legislating for a better food environment; and ensuring the availability of healthy food options to all at affordable prices (NSP 2013–2017 43).

The policy emphasised the importance of reduced salt intake; the introduction of food taxes on unhealthy food (those high in trans-fat and sugar); and subsidising healthy foods such as fruits and vegetables. Together, these would result in a modest to large positive impact on the nation's health (NSP 2013–2017 37).

With regard to salt consumption, the policy stated that regulations will be passed on salt content in processed foods, as well as the monitoring of salt content in food through public campaigns. It sought to achieve the

lowering of national overweight and obesity levels by increasing healthy eating habits in the population and disincentivising the consumption of unhealthy foods (NSP 2013–2017 62).

The NSP 2012–2017 set clear targets for diet-related NCD prevention, and notable progress was made between 2012 and 2018. Legislation included the sodium reduction regulations (Regulations Relating to the Reduction of Sodium in Certain Foodstuffs and Related Matters, 2013) and proposed amendments to food labelling and advertising regulations.

The latter included a restriction on health claims, prohibited certain statements, required nutritional information, and imposed a ban on advertising unhealthy food and a ban of advertising through cartoon characters, celebrities, and sports stars (Regulation R429). In addition, the Health Promotion Levy (HPL) imposed a tax on sugar-sweetened beverages (Health Promotion Levy 2018).

Despite some shortcomings in these regulations (and the fact of the backlash against them organised by the food industry), they certainly indicate the government's determination to actively address the growing burden of diabetes, obesity, and related diseases.

## The NSP 2022–2027's strategies for addressing unhealthy diet

The prevention of diet-related NCDs is a human rights imperative, one that highlights the relationship between the right to food and the right to health (access to adequate nutrition is recognised as a key determinant of the right to health ((CESCR General Comment 14, para 11)). The right to food is guaranteed in various international and regional human rights instruments, such as the International Covenant on Economic, Social and Cultural Rights, the African Charter on Human and Peoples' Rights, and the African Charter on the Rights and Welfare of the Child.

Section 27 of the South African Constitution similarly guarantees the right of access to food, while sections 28 and 35 specifically guarantee the right to food of children and of persons in detention. The government has the obligation to respect, protect and fulfil the right to food through reasonable legislative (as well as other) measures.

Besides addressing the systemic failures (such as poverty, inequality, and unemployment) which produce food insecurity and force low-income individuals and households into unhealthy diets, the government also has an obligation to take steps to protect people (through appropriate legal, regulatory, policy or fiscal measures) from the activities undertaken by food industry players to drive unhealthy diets.

> **"...the government also has an obligation to take steps to protect people..."**

South Africa has several legal and policy frameworks that are relevant to the prevention of diet-related NCDs; nevertheless, access to nutritious food remains a significant challenge.

While human rights are among the guiding principle of the NSP 2022–2027, this policy falls short in its obligations in respect of the right to food and health in so far as the latter relates to the prevention of diet-related NCDs. This is particularly evident in the policy's failure to set clear targets for addressing unhealthy diet, especially in relation to the food environment.

The decision to implement healthy nutrition policies in workplaces, schools, and ECDs and public institutions is admirable but confusing, given that the threat to health arising from the consumption of unhealthy food extends far beyond these specific areas, and is perhaps best understood at the level of the household. There is also a general lack of specificity around how policy should be engaged in the given settings. If children are understood to be a priority group (as is suggested by the focus on schools and ECDs), surely improved regulation of the advertising which directly targets children should have featured as a policy priority?

In general, the policy objectives fail to consider the unhealthy food environment linked to overweight, obesity and diet-related NCDs, despite the acknowledgement of the need for multisectoral action to address the commercial determinants of health (NSP 2022–2027 vii). The government is therefore failing in its obligation to take reasonable steps to protect people from the food industry and the damage it does to the citizen's enjoyment of the right to food and the right to health.

Both NSPs appear to suffer from a lack of a clear vison on the part of the Department of Health with regard to addressing unhealthy diet as a major risk factor for NCDs. Moreover, there is a lack of connection and continuity between the strategies and objectives of the NSPs. The NSP 2022–2027 makes no reference to the previous plan, or how it informs the new targets, despite its insistence that the guiding principles of the new NSP were identified after a careful review of the NSP 2013–2017 (NSP 2022–2027 24).

To have highlighted any specific challenges in implementation or any specific shortcomings in the previous plan would have provided useful insights into the raison d'être of the new policy priorities.

Similarly, stating what informed the priority given to schools, workplaces, ECDs and public institutions for healthy nutrition intervention would have helped to explain how the Department of Health determines those considered most vulnerable to diet-related NCDs. In this regard, the new plan appears to stand completely independent from the previous plan and does not seek either to build on its achievements or to address its failures.

Thus, the new plan fails to articulate specific targets or outcomes in relation to addressing unhealthy diets. It deals neither with the issues of labelling and advertising, nor with the question of strengthening the implementation of other relevant policies and regulations, such as expanding the reach of the sodium regulation as well as the HPL (the HPL could benefit from an increase in the tax imposed from the current 11% to the initial 20% recommended).

All in all, while the NSP 2022–2027 appears to prioritise prevention, it maintains a treatment-focused approach through integrated people-centred health services. As such, underlying factors such as deep-rooted inequity are largely disregarded and reflected only in relation to the fact of unequal access to health care and management. No consideration is given to the underlying inequities that continue to perpetuate the NCD burden through exposure to risk factors such as unhealthy diet.

We believe it is imperative to find the right balance between prevention and treatment, and this should be based on a careful analysis of the dynamics of the national context.

Cost-effective preventive measures to decrease population-level risk have always been championed as a viable means for low- and middle-income countries to address the growing burden of NCDs while at the same time maximising resources for treatment (WHO 2017). In addition to not requiring significant funds for implementation, regulatory intervention of the food environment can result in significant health-care savings (Manyema et al. 2016). Early diagnosis and treatment are the focus of clinical-preventive measures, but upstream intervention aims at controlling the risk factors and aim at the prevention of disease (Maher & Ford 2011). Clinical prevention does involve interaction with the health system, which in countries like South Africa, is already overburdened (and still trying to recover from the COVID-19 pandemic).

In sum, adequate regulation of the food industry is a very cost-effective intervention for the prevention diet-related NCDs when compared with clinical prevention. It needs to be given proper attention if the South African government is to maximise resources for the treatment of NCDs. The comparison between clinical prevention and upstream strategies to address unhealthy diets is not meant to suggest that the former is unimportant; rather, it seeks to underline the importance of setting clear targets to address these challenges.

**Cost-effective preventive measures to decrease population-level risk have always been championed as a viable means for low- and middle-income countries to address the growing burden of NCDs...**

# Conclusion

This article has provided a brief account of the current and preceding national strategic plans on the prevention and control of NCDs in South Africa, and an assessment of the existing approaches to diet-related risk factors. While NCDs are complex, the focus on diet-related risk factors helps to provide some insight into the government's approach to NCD prevention.

The approach of the most recent NSP appears to prioritise clinical prevention measures over upstream ones. This is a matter of concern in the national context of a rapidly expanding NCD burden amidst an increasingly unhealthy food environment and a severely constrained health system.

We argue that it is now imperative for targeted, cost-effective, and integrated prevention strategies to be prioritised, along with ensuring effective implementation and accountability mechanisms, even with the shortcomings of the NSP. Several policies and regulations are already in place and could be strengthened and integrated into South Africa's response to address the growing burden of diet related NCDs. There remains an opportunity to develop follow-up national plans and actions on how best to ensure the implementation of the current diet-related NCD framework.

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INTERVIEW

# Making equitable access to NCDs+ prevention and treatment a national priority: an Interview with Dr Vicki Pinkney Atkinson

Dr Victoria Pinkney-Atkinson, is the Director of the South African NCD Alliance. She holds a PhD in NCDs Healthcare Knowledge Management from the University of the Witwatersrand. She is a healthcare professional and activist with more than 50 years' experience in the field

## Could you please introduce yourself?

My name is Victoria (Vicki) Pinkney-Atkinson. I am a health-care professional with over 50 years of diverse experience in many settings. However, having life-long lived experience is my most important qualification for being an NCDs+ activist. It is not a profession that anyone in their right mind would choose, let alone a child in the critical first 500 days of life. Indeed, without the chronic skin condition of psoriasis, I might well have done something suitably meaningful, but that didn't need quite so much passion and grit.

Within my first 500 days, the 'silly little skin disease' was diagnosed. It resulted in stigmatisation, disability, and many severe comorbid health conditions. In the 1950s and 60s, many of these complications had yet to be acknowledged or identified. The reality is that psoriasis is a common autoimmune condition going beyond skin deep, and its complications often go unacknowledged or misdiagnosed. In later life, responses to drug treatment and psoriasis complications led me to at least three near-death experiences.

Currently, I am the Director of the South African Non-Communicable Disease Alliance (SANCDA), where my main focus is on NCDs+ activism framed by policy coherence.

## What is SANCDA's main advocacy objective?

Our main advocacy objective is that people in South Africa who use the public health services get equitable access to quality NCDs+ prevention and management throughout their life course without causing them financial hardship. If you recognise that is close to the definition of universal health coverage (UHC), well spotted!

Our advocacy has three main pillars that are parts of UHC: equity, quality and affordability (financial risk protection). The SANCDA+ uses the government's communicable disease (CD) programme, specifically HIV, TB and sexually transmitted infections (STIs), as the benchmark for policy and programme criteria. The rollout of National Health Insurance (NHI) must make that transparent and evident.

- ***Equity:*** People living with NCDs+ (PLWNCDs+) want equitable access to NCDs+ prevention and management services. This implies access to medicines for common NCDs+ conditions, convenient pickup points, etc. Since 2014, the government's Central Chronic Medicines Dispensing and Distribution (CCMDD) programme has provided extensive support for HIV and TB medication access. We want something similar for insulin users and diabetic supplies at primary health care (PHC) level within NHI districts and services.

- ***Quality:*** PLWNCDs+ want quality NCDs+ services based on transparently developed and implemented guidelines implemented at the PHC level with the accompanying evaluation, as is done for HIV and TB.

- ***Affordability:*** PLWNCDs+ want the full agreed package of services available close to home without incurring transport and out-of-pocket expenses due to ongoing supply chain problems. Again, we use the CD programme as a benchmark.

## The COVID-19 pandemic has exposed NCDs+ in the form of co-morbidities. How would you recommend they remain prioritised from a policy perspective?

Early in the pandemic, statistics from China showed that older persons were at the greatest risk of severe COVID-19 and death. This was markedly different from the Spanish flu of a century ago. Further analysis showed that while age is an independent risk factor, most seniors, and many younger people, have one or more NCD+.

NCDs+ are a significant part of the much-bandied term 'co-morbidities' or 'co-morbid conditions'. It became clear that the early diagnosis and adequate treatment that formed an essential part of NCD+ management was also crucial here, especially so in the public sector. For example, if a person with diabetes keeps blood-sugar levels down below a set level for over three months, the risk of COVID-19 complications or death, was reduced. Control in this instance is measured by an HbA1C test, something sadly not available in many PHC settings.

**Early in the pandemic, statistics from China showed that older persons were at the greatest risk of severe COVID-19 and death.**

For people living with CDs, the parallel reality simply meant continuing the existing care and treatment for which there was significant access even in hard COVID-19 lockdown. In South Africa, we have the world's largest group of people living with HIV and in ARV treatment. So, from the start of the pandemic, the National Department of Health's (NDoH) communication team only acknowledged CD as the most critical co-morbidity. The bias toward CDs as the most critical co-morbidity is understandable given the NDoH's considerable investment of money and human lives.

NCDs+, including obesity, were ignored, thus reinforcing the long-standing neglect of NCDs+ in the public health services. Time and time again, the SANCDA+ asked the NDoH to change its COVID-19 messaging about co-morbidities. To no avail: the state priority co-morbidities remained HIV and TB.

The reality is that only those who were poorly compliant or undiagnosed were at risk. Minister Mkhize included malaria as another critical CD co-morbidity on one memorable occasion. In mid-2021, government health messaging started including NCDs+ as significant co-morbidities.

The long-standing neglect of NCDs+ meant that most of the population that uses public health services go undiagnosed and untreated. When a person is diagnosed with an NCD+, the evidence shows that drug treatment is often not started or is poorly managed. So PLWNCDs+ are ripe breeding grounds for severe COVID-19 and death.

**The long-standing neglect of NCDs+ meant that most of the population that uses public health services go undiagnosed and untreated.**

## How would you assess the impact of COVID-19 on those living with NCDs+ (PLWNCDs+)

It is a huge burden on the health system, but is hidden from sight because the statistics about NCDs+ are so poor. When we reflect on this pandemic, apart from the fact of corruption and the failure of the health services, the great scandal is the neglect of NCDs+ within the public health system.

It is simply the case that South Africa does not routinely collect national data on NCDs+ as it does for every aspect of health related to CDs The epidemic's impact on NCDs+ is unknown, but we have more than an inkling about this from the hospital admission figures compiled by the National Institute of Communicable Diseases (NICD) in its DATCOV stats. Initially, only CD co-morbidities were recorded, but (thanks to the NICD's insistence) NCDs+ including obesity, were added to the list, albeit late in the day and not as part of the routine data collection. NCDs+ remained an optional extra!

Most people with COVID-19 die at home, possibly with an undiagnosed or uncontrolled NCD. The 'excess death rate' indicates we may be in for a rude awakening as we theoretically build back fairer post-NCDs+-19. The UN and WHO slogan for post-COVID-19 reconstruction as 'build back better'. In the case of NCDs+, this must be founded on UHC and include respect for human rights to start building back fairer.

The National Indicator Data Set (NIDS) collects vast amounts of CD information from the public health system and minimal NCDs+ data. That is the scandal. The NDoH doesn't care enough to know.

> **Most people with COVID-19 die at home, possibly with an undiagnosed or uncontrolled NCD.**

## How would you assess the varied impact on PLWNCDs+ from vulnerable and marginalised groups?

The COVID-19 pandemic has shown us that vulnerability comes in all shapes and sizes, and not just for the list of usual suspects. Until COVID-19, PLWNCDs+ were an unacknowledged vulnerable group.

Why? Government policy excluded PLWNCDs+ from equitable prevention, diagnosis and treatment despite being the fact of their being the leading cause of death in South Africa. NCDs+ are a priority neither in the National Development Plan nor for the government. Their cause has no champion amongst the political elites and parties.

## What would you say is the main cause of the increasing burden of NCDs+ in the country?

- The epidemical transition of societies and economies. This is a global phenomenon.

  NCDs+ are always present and seldom appropriately managed, particularly so among the poorest and most disadvantaged groups. These are euphemistically referred to as 'upstream' causes of health problems, or the social determinants of health. But they are much more than just the social. They include economic, commercial, and environmental causes. In South Africa that covers the broad swathe of people. The 2022 World Bank report regards South Africa as the 'most unequal country'. Most South Africans only have poor health care, and NCDs+, the largest group of health conditions, thrive in poverty.

- No political will to deal with NCDs+. The outdated government narrative dates back to the 2007 ANC Polokwane Conference when a focus on CDs was

vital and a new political elite swept into power. For example, the NDP, the NDoH and the President's labelling of NCDs+ as 'diseases of lifestyle' and seldom of poverty and inequity. As a lifestyle disease, the poor and neglected must take the rap of purposely getting an NCDs+. Blameworthiness is not a fault meted out to those who live with HIV or TB.

The National Development Plan (NDP) gets its mandate from the political domain, and the health chapter still champions CDs and millennium development conditions over NCDs+. NHI also appears in that chapter, but the abject failure of NHI to date mirrors the NDoH's continuing neglect.

## Would you think that the approach of the government to focus on management rather than prevention of NCDs+ is the right way to go? What suggestions would you offer?

It is not about either prevention or management – that binary remains the fatal flaw of the NDP 2030. It's actually impossible to deal with the one without the other. South Africa has to do both simultaneously in a rational and non-siloed manner. The trouble is that there is no transparent, inclusive discussion on how to do this. It can't be done with HIV and TB at the centre of the narrative.

The failure to adapt the NDP leaves the many millions of PLWNCDs+ without equitable access to treatment: basics like screening, diagnosis and evidence-based treatment in the government health system.

The NDP and policy emanating from it, the Medium-Term Strategic Framework (MTSF) 2019–2024, make it clear that population prevention measures and 'healthy lifestyles' are the only real interest. The MTSF is unequivocal in stating that there is no direct funding for NCDs+. This is, of course, a disaster for those of us living with NCDs+.

## What is your view on the NCDs+ National Strategic Plan (NSP) 2022–2027? Is this the document of your dreams?

The National Health Council approved the third NCDs+ NSP 2022–2027 recently and its launch [was] due at the end of May 2022. It certainly isn't a 'dream' policy; but it is a hard-won compromise that took all of the strength and limited resources of a determined group of NCDs+ activists.

The SANCDA+ forced the NDoH to address human rights issues, the exclusion of PLWNCDs+ and the issues of deliberate non-transparency. The gruelling eight-year advocacy battle involved influential stakeholder groups, including government departments and well-funded CD advocacy groups. Strong and well-connected forces supported the CDs status quo.

The third NCDs+ NSP is fundamentally different from its predecessor, which was, of course, neither funded nor implemented by the government. The NSP supports the concept of the Sustainable Development Goals (SDGs), but these goals are contraindicated by the existing siloed arrangements and would require truly integrated health care. That is the rub, and the point where the agreement ends.

**“The failure to adapt the NDP leaves the many millions of PLWNCDs+ without equitable access to treatment: basics like screening, diagnosis and evidence-based treatment in the government health system.**

## Over the years, you have worked extensively on NCDs+, focusing on addressing inequality in the health sector. Do you think there have been positive developments in this regard?

In the absence of political will, health inequity has grown because this suits the powerful. However, I think COVID-19 could be a great leveller if we take the lessons seriously and build back fairer. So far, COVID-19 has provided a window for policy change along with the alignment of Kingdon's three-streams theory.
NCDs+ (hence the reason for the + throughout this interview) are a large, diverse group of conditions, including mental health, motor vehicle accidents and disability.

The SDGs drive us towards UHC, and this would require that our local variant of NHI consider the people's real needs. It is so much more than a financial risk management system. And no amount of political desperation will convince those who use public health services that the current model is in the people's best interests.

2022 is a year of party-political manoeuvring. No political party has found NCDs+ a sufficiently worthy cause to address in its manifesto, though there are many promises of change to the health system in the air in the run-up to December. However, until the NDP and the MTSF change fundamentally, there is little hope.

Change will only come if every politician, their families and civil servants are forced to use the government health services they created to support dysfunctionality. Ban them all from access to private health insurance, and perhaps political will might return. I took that step about five years ago. It simultaneously terrifies me and galvanises me to action. During COVID-19, it has been some small comfort to know that I am with the approximately 80% of the population who are in the same sinking ship.

## SANCDA+ recently resubmitted a complaint to the South African Human Rights Commission (SAHRC) addressing inequality regarding access to health care and medicine. What role can quasi-judicial bodies play in addressing some of these challenges in relation to NCDs+? What about the courts?

Our open SAHRC complaint is under way. In it, we list seven human rights that are currently being violated. We cite the government's (and the Presidency's) failure to support our request to uphold our rights. A 2007 SAHRC hearing noted most of this, but nothing has changed since then. The complaint was submitted in 2020 and later resubmitted to extend the complaint's address beyond the national and provincial departments of health.

We are thankful that the SAHRC has registered our case and that it is progressing there, even though this is a fraught process, and a very slow one. Not that we are not grateful to the SAHRC; but this goes along the lines of 'beggars can't be choosers'. Once again, we know what it is like to be stuck with an unsellable and unpopular health condition.

The SANCDA+ human rights are a global first where we take all NCDs+, as a class of conditions, without fragmenting them into competing NCDs+ groups. NCDs+ advocacy organisations are the poorest of health civil society organisations

When discussing the prospect of litigation, there is inevitably the desire to pick a favourite NCD, depending on your worldview. Many factors colour this selection. These include the fact that many funding bodies want

to pick their target NCDs while others simply want to get the greatest media mileage from it. All this is very understandable.

One legal-cum-civil society organisation seriously said we should first raise R2 million (minimum), and then they would consider it. Even then, we might have to change our strategy and not ask for equity between NCDs+ and CDs. I kid you not.

NCDs+ are the greatest disease burden globally, but less than 2% of all donor funding goes toward NCDs+. Government funding for NCDs+ civil society activities is negligible. It stands at 1% compared to 99% for CDs. While CD funding is shrinking, it is still at levels beyond our wildest dreams. Yes, we know that much of this funding comes through donor funding and conditional grants. Facts are not equity food.

We secretly call the silent treatment we get from the government the 'Reverse Stalingrad Strategy'. We probably have had just one written response in eight years. It is as if their thinking is, 'If we don't respond and stay silent, you don't exist, and you will simply fade away. Stay schtum, and we will prevail.' So far, it has worked brilliantly and allowed state capture to flourish. We have extensive documentation of the neglect from government, politicians and officials.

**Yes, we know that much of this funding comes through donor funding and conditional grants. Facts are not equity food.**

UPDATE

# Complaint to the South African Human Rights Commission by the South African Non-Communicable Diseases Alliance

*Aisosa Jennifer Omoruyi*

*The South African Non-Communicable Diseases Alliance (SANCDA), an alliance of registered non-communicable diseases (NCDs) advocacy organisations, has lodged a complaint with the South African Human Rights Commission (SAHRC).*

The complaint alleges, among other things, a failure to make NCDs a priority given the burden of disease and the needs of People living with NCDs+ (PLWNCDs); weak NCDs data collection, surveillance, and monitoring; failure to evaluate and implement NCDs policies at all levels; and failure to provide resources and services for the prevention and control of NCDs. This has led to a failure to substantively manage NCD-related risk factors in the population as well as the health-care needs of PLWNCDs.

Flowing from this, the complaint alleges a violation of several rights protected in the Bill of Rights of the Constitution of South Africa including equality (section 9), dignity (section 10), the right to life (section 11); health care, food, water, and social security (section 27), environment (section 24(a)), the rights of children (section 28), access to information (section 32), and just administrative action (section 33).

Also highlighted in the complaint is that the emphasis on population-wide behavioural changes to curb 'lifestyle diseases' stigmatises PLWNCDs as responsible for their illness rather than focusing attention on structural and social factors that influence disease burden and on the role of government in disease prevention and control.

This complaint seeks to hold the whole of government to account for not dealing fairly and equitably with PLWNCDs and for giving less importance to NCDs than to communicable diseases. For instance, the National Development Plan (NDP) 2030 and its revisions have placed priority on communicable diseases and the National Health Insurance rather than NCDs, despite their being a fast-growing burden in South Africa and overtaking communicable diseases. Similarly, the Medium-Term Strategic Framework (2019–2024) has no budget for NCD prevention and control.

This trend features in other policies, both at national and provincial level, and has placed PLWNCDs, especially the already vulnerable and marginalised, in a dire situation.

The complaint thus seeks to have NCDs made a priority in the NDP and other relevant policies. Given the current

> **These failures result in inequitable access to essential treatment, rehabilitation, and palliative care at all stages, especially for the poor and vulnerable.**

threat which NCDs pose in South Africa, particularly in the context of the COVID-19 pandemic, the importance of renewed attention to NCDs prevention and control cannot be overemphasised.

In the same vein, the complaint seeks coherence in and implementation of policies aimed at NCDs prevention and control, both of which are currently lacking. These failures result in inequitable access to essential treatment, rehabilitation, and palliative care at all stages, especially for the poor and vulnerable. In this regard, the government must be compelled to ensure equitable access to the entire continuum of care without financial hardship.

The outcome of this complaint should result in health equity for PLWNCDs and making NCD prevention and control a national priority. This includes access to essential health services for chronic NCDs without financial hardship. To achieve this, the complaint maintains that NCDs should be included in all plans and policies related to achieving the SDG of universal health coverage as well as to bringing about the National Health Insurance.

Another important matter raised in the complaint relates to adopting a comprehensive description of NCDs, including mental health and disability through the life course. Achieving health equity as such would require this to be reflected accordingly in all policies relating to NCD prevention and control.

This is an important case at a time in South Africa when many of those living with NCDs have limited access to adequate health care services for the management of chronic illnesses yet are also threatened by COVID-19 due to their risk of serious complication and death from the disease. It will be important for this case to be given speedy attention by the SAHRC, as an unreasonable delay will defeat the urgency which the NCDs problem in South Africa requires and leave PLWNCDs in an even more vulnerable situation than they are already.

*Aisosa Jennifer Omoruyi is a postdoctoral researcher at the Dullah Omar Institute, University of the Western Cape, Cape Town.*

**“The outcome of this complaint should result in health equity for PLWNCDs and making NCD prevention and control a national priority.**

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