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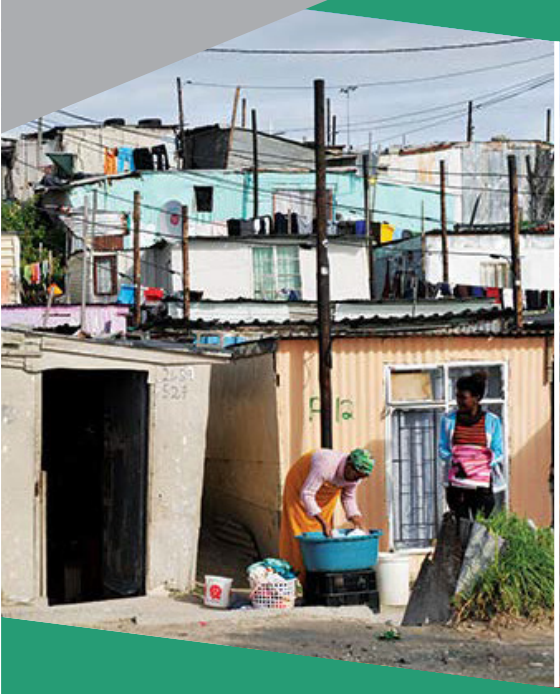
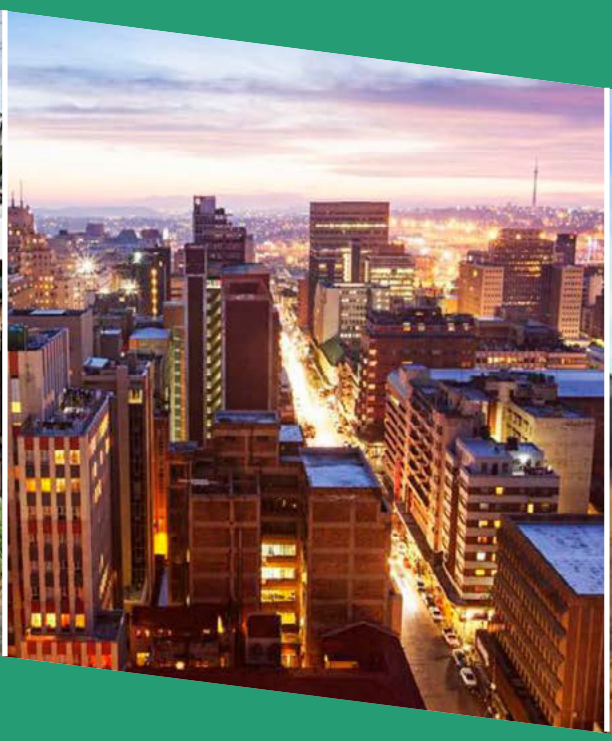
Volume 22
2021





# 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

A publication of the Dullah Omar Institute for Constitutional Law, Governance and Human Rights (formerly Community Law Centre) at the University of the Western Cape

**ISSN: 1684-260X**

A publication of the Dullah Omar Institute for Constitutional Law, Governance and Human Rights (formerly Community Law Centre), University of the Western Cape.



## ESR REVIEW ONLINE

https://dullahomarinstitute.org.za/socio-economic-rights/esr-review

## PRODUCTION

The ***ESR Review*** is produced by the SocioEconomic Rights Project of the Dullah Omar Institute for Constitutional Law, Governance and Human Rights, with the financial assistance of AmplifyChange and CS Mott Foundation.



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# Contents

# Editorial

Welcome to the first *ESR Review Special Edition* in a series on non-communicable diseases (NCDs). Covid-19 has put hypertension, cardiovascular diseases, diabetes, cancer and other NCDs in the spotlight, since people with these co-morbidities are at a heightened risk of serious ill-health, disease and death. The rise of NCDs around the world is worrisome as they are a major cause of premature death and disability. These diseases are particularly rife in developing countries, where they put strain on already overstretched health systems.

Globally, it is estimated that 41 million people die of NCDs every year, with 80 per cent of such deaths occurring in low- and middle-income countries. The rise of NCDs presents a huge economic burden in view of the cost of their management and the loss of productive output to which they lead. The increasing incidence of NCDs is driven largely by tobacco use, physical inactivity, harmful alcohol consumption and unhealthy diets. Consequently, more attention needs to be given to the prevention and management of NCDs through the implementation of effective legal and fiscal measures.

This requires strategies geared towards addressing modifiable risk factors and ensuring equitable access to health-care services for the treatment of NCDs, especially among vulnerable groups. This is critical not only for managing the strain of the pandemic on countries and their health systems, but for ensuring sustainable recovery in the future.

This special edition draws together contributions focused on NCDs, the constitutional and legal frameworks related to them, and their socio-economic implications.

The first article by Osaretin Christabel et al examines the health-justice framework in South Africa, the state's obligation to realise the right to health, and the health-care needs of vulnerable groups with NCDs both during and after the Covid-19 pandemic. The second article by Moses Mncwabe looks at the role of government institutions in responding to the growing epidemic of NCDs in South Africa. The third article by Megan Donald and Christiaan van Schalkwyk deals with environmental risk factors for NCDs, and considers the link between the right to health and a healthy environment by focusing on air pollution. The events section presents the highlights of a webinar series, hosted by the Socio-Economic Rights Project, on human rights and NCDs. In the updates section, we share observations on the Report of the Special Rapporteur on extreme poverty and human rights. We hope you find this issue stimulating and useful in continuing the fight for the right to health in the South and beyond. We wish to thank the anonymous peer reviewers and our guest authors for their insightful contributions.

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

FEATURE

# Applying the Health Justice Framework to Address Health and Health-care Inequities Experienced by Vulnerable and Marginalised Populations with Non-Communicable Diseases during and after Covid-19 in South Africa

*Osaretin Christabel Okonji, Ololade Shyllon, Oluwaseyi Aboyade and Gail Denise Hughes*

## Introduction

*Non-communicable diseases (NCDs) are increasing in South Africa, and are among the leading causes of death (StatsSA 2020). Vulnerable and marginalised groups (VMG) within the country have a greater NCD rate than advantaged populations (Di Cesare et al. 2013). In South Africa, vulnerable groups are that part of the population that experiences a higher risk of poverty and social exclusion than the general population (StatsSA 2018a).*

The Covid-19 pandemic has disrupted health services, reduced access to health care and increased inequity, especially among VMG. South Africa has the highest number of Covid-19 cases in Africa, with more than 2.3 million registered cases and over 66,000 related deaths (Africa CDC 2021). The risk of severe illness and mortality among people infected with Covid-19 has been widely observed among people with co-morbidities, particularly NCDs (NICD 2021).

Covid-19 disproportionately affects VMG, particularly among people with a low income and of African descent (NICD 2021: 1; Shaw et al. 2021). Similarly, NCDs disproportionately affect VMG, thus increasing their risk of severe disease and mortality from Covid-19 (Di Cesare et al. 2013; Kushitor et al. 2021). These disadvantaged groups remain undiagnosed, untreated, and at greater risk of preventable complications (Kushitor et al. 2021). VMG often experience the simultaneous occurrence of more than one chronic disease, along with poor health and its outcomes, because of limited access to health care (Ataguba 2013; Ataguba, Akazili & McIntyre 2011). These are not recent occurrences but symptomatic of deeply rooted injustices that have existed for far too long. Although the South African government has tried to improve access to health care for these groups, health inequality persists.

Access to health care is a fundamental human right

recognised by the South African Constitution of 1996, the supreme law of the land. Section 27 of the Constitution guarantees the right of everyone to access health-care services, which in turn requires that the state take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of this right. Despite this guarantee, VMG with NCDs continue to have inadequate access to health care (Ataguba 2013; Ataguba, Akazili & McIntyre 2011). Although the government aims to address health reforms through the National Health Insurance (NHI) Bill, implementation has been delayed (South African Human Rights Commission [SAHRC] 2018).

Against that background, this article argues for the necessity of a comprehensive response that addresses the immediate needs of VMG, particularly in regard to NCDs during Covid-19, as well as the root problems that have caused persistent and long-lasting inequities. We draw on an emergent health justice framework (Benfer et al. 2020) and link it with human rights for eradicating health inequities experienced by VMG.

## Health and health-care inequities

South Africa faces a quadruple burden of disease: HIV/AIDS and tuberculosis; high maternal, neonatal and child morbidity and mortality; high levels of violence and trauma; and the recent upsurge of NCDs (Michel et al. 2020). VMG are more likely to be diagnosed with chronic NCDs (such as diabetes mellitus, cardiovascular diseases, chronic lung disease, kidney and liver disease, and cancer) and multi-morbidity (the occurrence of two or more NCDs) (Biney, Amoateng & Ewemooje 2020; Kushitor et al. 2021). VMG include the unemployed, females, blacks, coloureds and Indians, the elderly and uneducated, and those living in extended households and at greater risk of developing NCDs; they have higher rates of multi-morbidity, which compounds their health status (Weimann, Dai & Oni 2016; Biney, Amoateng & Ewemooje 2020).

Health inequalities existed in the South African population before Covid-19 (Ataguba, Akazili & McIntyre 2011). South Africa remains one of the most economically unequal countries globally: advantaged groups can access health care via the private sector, while the poor rely on an under-resourced public sector (Michel et al. 2020). Health and health-care disparities among VMG are deeply rooted in the structures of apartheid and are thus based on a history of segregation and mistreatment by the health-care system (Coovadia et al. 2009). Only 9.9 per cent of blacks have medical insurance, compared to coloureds (17.1 per cent), Indians/Asians (52 per cent), and whites (72.9 per cent) (Stats-SA 2018b). Many VMG, predominantly black South Africans with NCDs, experience much worse health-care outcomes and barriers to care, probably as a result of factors such as unemployment, poverty and lack of medical aid. These data highlight the continuing violation of the right to health, and demonstrate a violation of closely linked and interdependent rights. These include the right to life, human dignity, and non-discrimination and equality.

Since VMG with NCDs are often uninsured, they rely on public health facilities (PHF) (Ataguba, Day & McIntyre 2015; Di Cesare et al. 2013), which poses many challenges. These include long waiting times; drug stock-outs; shortages of emergency transport; limited infection control; understaffing; and discriminatory staff attitudes towards vulnerable groups (SAHRC 2018; Michel et al. 2020). Such challenges are aggravated by unequal distribution of health resources (such as a lack of health facilities, health-care professionals, and inadequate recruitment), particularly in rural areas (Rispel 2015). The situation in PHF is exacerbated by underfunding, widespread corruption, mismanagement of funds, misconduct, and a lack of accountability (Rispel 2015).

> **South Africa has the highest number of Covid-19 cases in Africa, with more than 2.3 million registered cases and over 66,000 related deaths (Africa CDC 2021).**

As a result, many VMG are forced to make use of multiple health systems to manage their chronic NCD conditions. For example, some studies report a greater prevalence of complementary and alternative medicine (CAM) usage for NCDs among individuals with a low socio-economic status, older women, rural dwellers, and persons with less education (Aboyade et al. 2016; Hughes et al. 2020). Using CAM may interfere with biomedical treatment, resulting in poor health outcomes or potentially adverse events. Thus, VMG are less likely to receive preventative health-care services for, and information about their chronic conditions.

The health needs of VMG with NCDs are complex and intersect with the economic and social conditions they experience. For example, reports on the social determinants of health have shown that these groups face inequalities, whether political, economic, environmental, social, or cultural, including deficient human rights and gender equality (Ataguba, Day & McIntyre 2015). VMG with NCDs experience more poverty and food insecurity, as well as lower employment rates, and have lower levels of education (Kushitor et al. 2021; Weimann, Dai & Oni 2016; Biney, Amoateng & Ewemooje 2020).

Given the pervasive health and health-care inequities that VMG with NCDs were already experiencing before Covid-19, it is not surprising that these injustices have increased as a result of the pandemic. VMG, particularly those with NCDs such as diabetes, heart and lung disease, hypertension, renal disease, and cancer, have experienced multiple forms of vulnerability. They are at an increased risk of becoming ill and facing critical outcomes (NICD 2021: 1). For example, during the pandemic, many cancer patients had no access to oncology services (Boikhutso et al. 2020). These VMG experience barriers to testing for Covid-19. They face poor outcomes because of their marginalisation and the persistent disadvantages imposed by structural inequities. Covid-19 mortality among the VMG may reflect their increased level of exposure to the virus, to the burden of co-morbidities, and to challenges in accessing health care (Hughes et al. 2021). Furthermore, VMG carry a disproportionate burden of the economic, social and health-related impacts of Covid-19, which distracts them from NCD self-care. Many VMG also disproportionately bear the effect of lockdowns and social distancing regulations, usually in settings where food insecurity and job scarcity influence access to health care.

During the lockdown, there was an interruption in essential health services, particularly in under-resourced settings where patients avoided accessing health facilities for follow-up and NCD prescription refills. PHF were overburdened with Covid-19 patients, limiting access to persons with NCDs. The inequalities plaguing disadvantaged groups with NCDs during the pandemic extended beyond poor health outcomes and impacted on all the social determinants of health, resulting in reduced access to health-care services and information and in unfavourable consequences.

South African VMG with NCDs experience a range of health injustices, which have worsened during the Covid-19 pandemic. Although biological factors, as well as individuals' risky behaviour, account for some of the health disparities, there is increasing evidence that many of the injustices can be linked to the social determinants of health (Ataguba, Akazili & McIntyre 2011).

**These data highlight the continuing violation of the right to health, and demonstrate a violation of closely linked and interdependent rights.**

## Applying the health justice framework

Health justice is an emerging framework which uses law and policy to eliminate structural inequities that cause poor health outcomes and experiences (Benfer et al. 2020). This framework emphasises access to quality health care and engagement with social, economic, and environmental factors that affect the health and welfare of marginalised populations. Health justice builds upon the concept that social determinants of health are as vital to an individual's health as the health care he or she receives. These researchers have proposed using the health justice framework to develop and implement laws and policies that prevent or eradicate health disparities during and after the Covid-19 pandemic (Benfer et al. 2020).

The researchers suggest four interrelated principles for addressing inequities during and after the pandemic. First, laws and policies should address the effects of poverty and discrimination on the social determinants of health and look at how crises intensify these inequities for marginalised groups. Secondly, legal and policy responses mandating behaviours or conduct should be supplemented by legal protection and support in order to accelerate compliance without advancing social and economic inequities. Thirdly, laws and policies must respond to the immediate needs of marginalised populations, as well as to the root problems that have prompted longstanding injustices. Lastly, members of VMG must be involved and engaged throughout the development and implementation of interventions to address health justice (Benfer et al. 2020). Thus, the health-justice framework provides a solid basis for tackling the urgent needs of VMG with NCDs that have become apparent during the Covid-19 pandemic, as well as for addressing long-standing inequities.

To demonstrate the application of the health justice framework and principles, we describe how law and policy should respond to the health and health-care injustices experienced by VMG with NCDs during Covid-19 and beyond. We propose legal and policy considerations relating to health-care access and quality as social determinants of health that must be addressed to achieve health equity among these disadvantaged groups, with the right to health used as the foundation. South Africa's legal and policy framework on health is a combination of international and domestic obligations. Internationally, article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR), with South Africa a state party, requires the government to recognise the right of everyone to the enjoyment of the highest attainable standard of health, including the prevention, treatment and control of epidemic, endemic, occupational and other diseases. Similarly, article 16 of the African Charter on Human and Peoples' Rights enshrines the right of every individual to enjoy the best attainable state of health. Domestically, section 27 of the Constitution guarantees the right of everyone to have access to health-care services.

> **We propose legal and policy considerations relating to health-care access and quality as an social determinants of health...**

However, the ICESCR and the Constitution limit implementation of the right to health by requiring 'progressive realisation' within 'the availability of resources' of states. Thus, full realisation of the right to health cannot be achieved immediately but over time. The UN Committee on Economic, Social and Cultural Rights (CESCR) has established that there are minimum core obligations that states must implement; in doing so, states are required to prioritise the most vulnerable members of society (General Comment 3, CESCR). In interpreting article 12, the CESCR concludes that the limitations of progressive realisation and available resources do not detract from the obligation of states 'to take steps' which must be 'deliberate, concrete and targeted'. These steps include adopting legislation, ensuring that judicial remedies are available, and taking other appropriate administrative, financial, educational, and social measures (General Comment 3, CESCR).
In South Africa, the Constitutional Court has affirmed, in the Grootboom case [(2001) ZACC, 19], that socio-economic rights implementation imposes an obligation on

the state to (a.) take reasonable legislative and other measures; (b.) achieve progressive realisation; and (c.) do so within available resources. While 'reasonable legislative measures' require coordination between spheres of government and the provision of the necessary financial and human resources, 'progressive realisation' requires the state to take steps to ensure that the basic needs of all society are met effectively. What is more, the 'legal, administrative, operational financial hurdles should be examined and, where possible, lowered over time'.

Essentially, legal measures alone are insufficient to address the disparate impact of Covid-19 on VMG with NCDs. A combination of practical legal, administrative, and social interventions that prioritises the health needs of VMG with NCDs is needed. However, an essential first step is the development of appropriate and effective laws and policies to address the health needs of VMG with NCDs.

In its General Comment No. 14, the CESCR stipulates the core components of the right to health. These are availability, accessibility, acceptability and quality. We rely on these components in setting out the specific measures that South Africa should take to ensure that VMG with NCDs have access to health-care services during and after the pandemic.

## *Availability*

Well-functioning PHFs must be available in sufficient numbers to cater for the needs of VMG with NCDs. These facilities must also have adequately trained medical and professional personnel, as well as Covid-19 medication and other essential drugs for treating NCDs. The rationing of basic health-care resources and specialised care such as renal dialysis and critical care for chronic NCDs that affect VMG must be addressed. For example, as reported, cancer patients were sent home to die because of a shortage of anti-cancer medicines and equipment failures at the PHF during the pandemic (Boikhutso et al. 2020). While public-private partnerships for chronic NCDs (including cancer) have been proposed (Ndungane 2021), the state bears the primary responsibility for ensuring that access to health care for VMG is prioritised, given the latter's heightened susceptibility.

**However, an essential first step is the development of appropriate and effective laws and policies to address the health needs of VMG with NCDs.**

## *Accessibility*

The element of accessibility requires an absence of discrimination at PHFs, and comprises four key components:

- Non-discrimination: Everyone, especially VMG with NCDs, must, in law and practice, be able to access health-care facilities without discrimination.

- Physical accessibility: Health-care facilities, medical services, and the underlying determinants of health, such as water and sanitation, must be within safe physical reach of VMG with NCDs. Data on Covid-19 in South Africa and other settings have shown that death was pronounced among certain VMG (those of African descent) (NICD 2021; Hughes et al. 2021), many of whom had chronic NCDs. This situation can be addressed by offering a range of health services in communities with low-income VMG with NCDs, such as home-testing and telehealth services. Furthermore, as vaccines become available, VMG with NCDs should be prioritised, given their higher vulnerability when exposed to the virus than those without NCDs.

- Economic accessibility: Health care must be affordable for all. Payment for health-care services must be based on equity, ensuring that publicly or privately provided services are also affordable for VMG. Those with NCDs must not be burdened with more health expenses than wealthier households. In particular, steps must be taken to ensure that the low-income status of VMG with NCDs is not a barrier to accessing life-saving health care, pending the rollout of the NHI.

- Information accessibility: VMG with NCDs should be given the opportunity to seek, receive and impart information on their health conditions. Given the widespread misinformation on preventing and treating Covid-19, including misinformation about vaccinations, specific steps must be taken to ensure that accurate and reliable medical information is accessible to VMG with NCDs. Long-lasting disparities in education that impair the ability of these groups to access health-care services and information should also be addressed, possibly by involving doctors and specialists from disadvantaged groups to communicate accurate information. As has been suggested by researchers (George et al. 2019), this would help address biases and lead to better health outcomes for VMG with NCDs.

> **Health care must be affordable for all.**

## *Quality*

Health care must be scientifically and medically appropriate and of good quality, which requires the administration of services by skilled medical personnel and the provisioning of scientifically approved drugs, efficient hospital equipment, safe water and adequate sanitation. There is no doubt that poor environmental and housing conditions have negatively impacted the health disposition of VMG with NCDs during the Covid-19 pandemic. Many with low socio-economic status live in informal settlements, where pollution and a lack of potable water and sanitation make them vulnerable to contracting Covid-19 (Shaw et al. 2021).

Despite the government's best efforts to address the Covid-19 pandemic, it is anticipated that trends in NCDs will remain heightened in the aftermath of the pandemic and affect the achievement of the Sustainable Development Goal 3.4 target of reducing premature death. Therefore, adopting a rights-based approach to address health inequities in South Africa is a matter of urgency. The Law Trust Chair in Social Justice at Stellenbosch University, which, inter alia, monitors and implements Covid-19 policy responses, can play a significant role in compelling the government to prioritise health justice for VMG with NCDs during and beyond the pandemic.

## Conclusion

The Covid-19 pandemic has disproportionately affected vulnerable and marginalised populations in South Africa. It has been devastating for these disadvantaged communities, and especially so for those with NCDs. The pandemic has exposed the long-standing and pervasive health and social inequities that VMG with chronic disease experience. Addressing these injustices is a crucial issue that demands broad consideration by policy-makers, legal professionals, and researchers.

The South African government must apply the health-justice framework that recognises core human rights principles on the right to health as a foundation for tackling increasing NCDs among VMG. The government should recognise that health extends beyond health systems. As such, laws and policies must be developed to ensure that VMG with NCDs can access essential resources such as food, water, transportation, and housing as fundamental human rights.

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*We acknowledged Jean Fourie, for editing of the manuscript.*

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FEATURE

# The Effectiveness of Government Institutions in Responding to the Epidemic of NCDs

*Moses Mncwabe*

## Introduction

*South Africa has not been spared from the global rise of non-communicable diseases (NCDs). A lack of funding and insufficient human resources to deal with NCDs have caught the international community by surprise. These diseases have increased greatly in various countries, prompting urgent comprehensive government responses. In South Africa, tobacco use, the harmful use of alcohol, unhealthy diets, and physical inactivity have all been identified as key drivers of NCDs. Another factor contributing to the increase of NCDs in South Africa is the pattern of migration from rural to urban areas. This has led to the rapid growth of informal settlements, which have neither recreational facilities nor safe walking paths to encourage physical activity (Juma et al. 2019; Bloom, Chisholm, Llopis et al. 2011).*

This article discusses the mandate and functions of the public health sector, and juxtaposes this with the national legislature's mechanism for oversight on the public health sector's remit on NCDs. It also discusses instances where the South African Human Rights Commission (SAHRC) has played its constitutional role in dealing with the health department's shortcoming in dealing with NCDs. The article concludes by highlighting various court judgments in this regard.

**A lack of funding and insufficient human resources to deal with NCDs have caught the international community by surprise.**

## Overview of the world's top NCDs

NCDs are defined as medical conditions or diseases that are non-communicable. NCDs are often chronic diseases of long duration and slow progression, and may result in more rapid death, such as in the case of a sudden stroke (Stuckler 2008).

The World Health Organization (2020) has stated that the world's main killer is ischaemic heart disease, which is responsible for 16 per cent of the world's total mortality. Ischaemic heart disease has increased exponentially over the years. This condition is followed by stroke and chronic obstructive pulmonary (COP) diseases as the second and third leading causes of mortality, being responsible for approximately 11 and 6 per cent of total deaths, respectively. Trachea, bronchus and lung cancers are reported to have risen from 1.2 million to 1.8 million, making them some of the leading causes of mortality globally.

## The burden and prevalence of NCDs in South Africa

The burden of disease in South Africa, specifically of NCDs, is concerning, as it contributes to 57 per cent of all mortality in the country. In addition, NCDs lead to various impairments such as amputations, blindness, hemiparesis and speech problems (Abegunde et al. 2007; Richards et al. 2016). Between 2006 and 2015, diabetes, stroke and coronary heart disease caused an estimated loss of $1.88 billion to South Africa's gross domestic product (Richards et al. 2016; Statistics South Africa 2017). This financial burden stems from the direct and indirect costs of high absenteeism and staff turnover as a result of NCDs.

The prevalence of NCD morbidities is higher among the working-age population in South Africa than in some of the developed countries in the West. Low- and middle-income countries, including South Africa, incur considerable expenditure due to lifestyle diseases that place a burden on their revenue-generating ability. This is caused by a combination of health costs and worker benefits, such as sick leave (Patterson, Smith & Hostler 2016). The direct costs incurred by employers include medical referrals, increased absenteeism, presenteeism, medical boarding, as well as hiring workers to replace the deceased and temporary workers to stand in for long-term sick or medically boarded employees (Patterson, Smith & Hostler 2016). South Africa has to respond urgently to the prediction that over the next decade, NCDs are likely to increase and cause more harm (Harikrishnan, Leeder & Jeemon 2014; World Health Organization 2014). To this end,

South Africa's Strategic Plan for the Prevention and Control of Non-Communicable Diseases for 2020-2025 is multifaceted and aimed at reducing harmful drivers of NCDs such as physical non-activity, alcohol abuse, tobacco, and environmental factors (Bloom, Chisholm, Llopis et al. 2011).

## Mandate and functions of the public health sector

The National Department of Health (NDOH) is mandated by the country's Constitution to provide health services to all South Africans. Section 27 of the Constitution provides the right of access to health-care services for everyone. Moreover, the National Health Act 2003 (Act 61 of 2003) (NHA) gives effect to section 27, which lays the base of the health-care system. The NHA aims, inter alia, to

- provide a framework for a structured uniform health system within the Republic, taking into account the obligations imposed by the Constitution and other laws of the national, provincial and local governments when it comes to health services; and

- provide for a system of co-operative governance and management of health services, within national guidelines, norms and standards, in which each province, municipality and health district must address questions of health policy and delivery of quality health services.

Furthermore, the National Development Plan (Vision 2030), the health sector's Ten Point Plan and the United Nations (UN) Sustainable Development Goals 2030 (SDGs) underscore the role and centrality of the public health sector. In recognition of this mandate, the NDOH compiled a five-year strategic plan (2014-19) to implement its preventative and response plan.

**The prevalence of NCD morbidities is higher among the working-age population in South Africa than in some of the developed countries in the West.**

## Domestic, international and continental human rights instruments

South Africa has moved from the fragmented health system it had under apartheid towards a democratic dispensation which recognises health reforms and affirms human rights that were previously disregarded. For example, section 27(1)(a) of the Constitution entrenches the right of access to health-care services, including reproductive health-care services. Section 27(2) and (3) enjoin the state to take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of, among other things, health care rights. It is on this constitutional basis that the state provides health services and prevents harm to the public arising from varied causes, such as NCDs.

In addition, two international human rights instruments underscore that health (and, by implication, the prevention and treatment of NCDs) is a fundamental right:

- The African Charter on Human and People' Rights guarantees civil, political and socio-economic rights as enforceable rights. Importantly, its article 16 guarantees the right to health by providing that every individual shall have the right to enjoy the highest attainable state of physical and mental health.

- The Protocol to the African Charter on Human and People's Rights on the Rights of Women demonstrates the African Union's commitment to the realisation of human rights, particularly for women, whose rights are often trampled upon by men and authorities (Roux 2020).

## National oversight mechanisms on NCDs

The national legislature has two houses, namely the National Assembly and National Council of Provinces (NCOP). They have two things in common. First, they have committees comprising members of political parties represented in the legislature. Secondly, they use committees to facilitate public participation and exercise oversight of the executive and state departments and bodies (Juma et al. 2018). The following are examples of laws the legislature has passed to respond to the threat of NCDs:

- The Tobacco Products Control Amendment Act (Act 63 of 2008) was passed to protect children and adolescents from tobacco advertising. The Act also protects the rights of non-smokers by ensuring a smoke-free public environment (Harikrishnan, Leeder & Jeemon 2014).

- The Liquor Act (Act 59 of 2003) was passed to encourage a responsible and sustainable liquor industry through promoting a culture of social responsibility and preventing the advertising of liquor to children (Van Walbeek & Blecher n.d; Roux 2020).

The legislature holds the executive to account on the grounds of under-service or suspicion of dereliction of duty with respect to NCDs. All of these mechanisms are designed to ensure that the public enjoys the best quality of life free of NCDs.

**South Africa has moved from the fragmented health system it had under apartheid towards a democratic dispensation...**

## Legislative mechanisms to engage the executive on NCDs

In fulfilling its responsibility, the legislature uses the following mechanisms to engage the executive on NCDs:

***Public submissions:*** This is where members of the public petition the committee of choice and detail the matter of concern requiring investigation and intervention by the committee. Members of the public can engage with the committee concerning NCDs.

***Member statements and executive responses:*** This is where any matter of importance is raised on the floor of the house to bring it to the attention of the executive. Parliamentary committees: Multiparty committees of 11 to 13 public representatives serve as an extension of the house of the legislature. These committees have constitutional powers to oversee government departments, including the power to summon any person or company for their purposes. The bulk of parliamentary work is done by such committees, which attend to departmental budgets, NCDs and other matters.

***Taking parliament to the people (TPTTP):*** This refers to proactive oversight by the NCOP, such as when it visits a province to consider specific outcomes with mayors, members of executive councils, premiers and ministers. In 2018, the TPTTP was held in Free State and focused on the status of health services.

***Oversight visits:*** These are announced or unannounced oversight visits by Parliament's committees to state organs and health facilities. The intent of oversight visits is to improve service delivery and increase accountability. Concerning NCDs, the Portfolio of Health of the National Assembly and the Select Committee on Social Services of the NCOP prioritise the determinants of health, which are major contributors to the rise of lifestyle diseases.

Moreover, the legislature is mandated to represent the interests of South Africans in the global arena on issues such as politics, the economy, the environment, tourism, culture and health (including, by implication, NCDs). The platforms where the legislature shares with, and learns from, its peers on the management of and responses to NCDs are:

- the Pan African Parliament;
- the Inter-Parliamentary Union;
- the Commonwealth Parliamentary Association; and
- the Southern African Development Community Parliamentary Forum.

> **Multiparty committees of 11 to 13 public representatives serve as an extension of the house of the legislature.**

## The SAHRC's involvement in NCDs

The South African Human Rights Commission (SAHRC, or the Commission) is mandated by section 184 of the Constitution to monitor, protect and promote human rights as set out in the bill of rights of South Africa's Constitution. As part of its mandate, the Commission received a complaint alleging that cancer patients in KwaZulu-Natal were not being treated due to a shortage of radiotherapy equipment and to out-of-service machinery at Addington Hospital (Parliamentary Monitoring Group 2017).

The Commission's assessment established that the allegations related to the right to access health-care services, as enshrined in section 27 of the Constitution. In this regard, the Commission found that the KwaZulu-Natal Health Department had violated the rights of oncology patients at the Addington and Inkosi Albert

Luthuli Central Hospitals to have access to health-care services, given the hospitals' failure to comply with norms and standards set out in legislation and policies. In terms of section 13(1)(a)(i) of the SAHRC Act, the Commission released binding recommendations for the respondents to implement immediately (Parliamentary Monitoring Group 2017).

Another intervention by the Commission on NCDs was prompted by the Life Esidimeni tragedy that claimed the lives of at least 144 psychiatric patients. These patients were removed in haste to under-equipped and ill-resourced non-governmental organisations (NGOs) in Gauteng. The relocation affected a total number of 1,711 mentally ill patients. In its investigation, the Commission found, first, that mental health is a neglected condition and characterised by violations of rights in the form of cruel, degrading and inhumane treatment that places mental health patients at greater risks. Secondly, it found that there was a bed deficit in existing facilities for children and adolescents with intellectual and psychosocial disabilities (Parliamentary Monitoring Group 2017). This shows the intersection of the Commission and the legislature in championing the right to quality health care and ensuring that dereliction of duty by the government is corrected and health-care services rendered effectively.

> **...mental health is a neglected condition and characterised by violations of rights in the form of cruel, degrading and inhumane treatment that places mental health patients at greater risks.**

## Examples of court judgments on NCDs

Despite the public health sector's aim to provide quality health care, there have been court cases that have been adjudicated in favour of the litigants. With respect to NCDs, cancer, diabetes and high blood pressure appear to be the main illnesses at issue in cases of medical negligence. For example, in September 2010, the High Court of South Africa issued a judgment (case no. 1037/2007) against the Eastern Cape member of the executive council for health and the superintendent of Dora Nginza Hospital. The Court found that the litigant's clinical records showed that the facility was aware of the litigant's condition, but contravened best practices – hence the judgment given against the defendants.

In another case, the High Court and Supreme Court of Appeal ruled in favour of mining companies alleged to have been complicit in the spread of an occupational disease, silicosis, among their former employees. This matter was ventilated at the Constitutional Court. The judgment was against the mines and found that the Compensation for Occupational Injuries and Diseases (COIDA) Act 1993 is not an impediment for employees to sue their employers. This judgment paved the way for a class action, which was instituted, certified and settled with a settlement of R5 billion, approved by the court, to compensate affected former employees (Constitutional Court of South Africa 2011).

## Conclusion

This article highlighted the roles that different organs of state play in ensuring a life for all, including those with NCDs. It illustrated how the legislature, in its totality and through different branches such as committees and TPTTP, exercise their remit to scrutinise departmental budgets, assess expenditure and demand proactive responses to NCDs. Similarly, the SAHRC and the courts have played their part in ensuring that the state corrects its shortcomings concerning NCDs. Though it is not ideal for the state to be ordered by the court to fulfil its remit, in this imperfect world both the SAHRC and courts have an important role to play in ensuring that the state fulfils its constitutional obligation towards the full realisation of health rights by the public. However, the continued accessibility of tobacco and alcohol, particularly by young people, demonstrates a gap in enforcement, as does the absence of clear communication by the government discouraging excessive intake of alcohol.

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FEATURE

# Environmental Risk Factors for NCDs: The Interdependence between the Right to Health and a Healthy Environment

*Megan Donald and Christiaan van Schalkwyk*

## Introduction

*The condition of the environment is a significant determinant of health. According to the World Health Organization (WHO), an estimated 13 million deaths each year are attributable to known and avoidable environmental risks (WHO 2020: 4). A host of environmental challenges, including droughts, heat-waves, air and water pollution, degradation and contamination of land, extreme weather events, and loss of biodiversity, pose critical threats to health. Climate change and environmental degradation not only contribute to the incidence of infectious diseases, such as the Covid-19 pandemic, but also affect the prevalence and severity of a range of non-communicable diseases (NCDs).*

As it is not possible to address the full range of environmental risks here, this article will focus on air pollution. Air pollution is linked to premature deaths from NCDs, including strokes, ischaemic heart disease, chronic obstructive pulmonary disease, acute lower respiratory infections, and lung cancer; it is also a major cause of pneumonia, bronchitis and asthma in children (Academy of Science of South Africa [ASSAf] et al. 2019: 2). It has been estimated that, globally, air pollution contributes to at least 5 million premature deaths annually (ASSAf et al. 2019: 1).

The health-related burden of air pollution is often disproportionately placed on the vulnerable and marginalised, including women, children and those living in poverty. In 2019 the severity of the threat prompted five National Academies of Sciences and Medicine (including the ASSAf) to propose 'the adoption of a global compact on air pollution to make air pollution control and reduction a priority for all' (ASSAf et al. 2019: 1).

In South Africa, the relationship between poor air quality and NCDs is of particular concern. A 2016 report from the World Bank and the Institute for Health Metrics and Evaluation at the University of Washington indicated that in South Africa about 20,000 deaths a year are linked to air pollution (World Bank and Institute for Health Metrics and Evaluation 2016: 100).

Effectively managing NCDs requires the consideration of relevant environmental risk factors and determinants. Given the relationship between the environment and NCDs, the state's constitutional obligations in this regard should be understood in view of both the right of access to health-care services in section 27 and the environmental rights in section 24 of the Constitution. In this article, we consider the role of both these rights in the prevention and treatment of NCDs that are caused or exacerbated by environmental factors. We also explore the possibilities presented by seeing these rights as interdependent.

## The right to access health-care services

The right of access to health-care services is contained in section 27(1)(a) of the Constitution. Section 27(2) qualifies the positive obligation to realise the right contained in 27(1)(a) by providing that '[t]he state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of [the right]'. The main negative obligation associated with the right is contained in section 27(3), which provides that no one may be refused emergency medical treatment.

> **Resources should rather be allocated to preventative health care interventions.**

The jurisprudence on section 27(1)(a) is limited. In *Soobramoney v Minister of Health* (1997) (*Soobramoney*), the Constitutional Court interpreted sections 27(1)(a), 27(3) and the right to life in section 11 of the Constitution. The appellant, Mr Soobramoney, was refused access to a dialysis treatment programme at a public hospital as he did not qualify for a kidney transplant, due to lifestyle diseases.

The Court's interpretation of the right of access to health-care services was narrow in *Soobramoney*, as the claim was based primarily on sections 27(3) and 11 of the Constitution. In regard to section 27(1), the Court reasoned that the resource constraints experienced by the hospital, such as a limited budget, were inconsistent with the argument to provide dialysis treatment to persons with no chance of recovery. Resources should rather be allocated to preventative health care interventions. The Court therefore exclusively defined and limited what the right of access to health-care services encompasses in terms of existing resources and budgetary considerations (Pieterse 2004: 891; Liebenberg 2016: 139).

*In Treatment Action Campaign v Minister of Health* (2002), the Constitutional Court adopted a similar interpretive position as it did in *Soobramoney*. The case concerned the question of whether the obligation to provide access to health-care services includes the provision of nevirapine, an anti-retroviral drug, to pregnant women with HIV/AIDS. The Court based its analysis on the reasonableness of the decision to exclude women and children from the programme providing nevirapine, which concerns section 27(2). The Court reasoned that section 27(1) 'does not give rise to a self-standing and independent positive right enforceable irrespective of the considerations mentioned in section 27(2)' (para 39). Consequently, the realisation of section 27(1) is subject to available resources and the reasonableness of the measures taken (Brickhill & Ferreria 2014: 591; Liebenberg 2016: 176).

Academic commentary on the right has been more extensive. 'Health' in section 27(1)(a) has been understood as encompassing various dimensions and factors, including 'biological, behavioural, cultural, environmental, social, economic and health-system-related determinants' (Pieterse 2008: 555). Such an understanding would support a reading of section 27(1) that includes obligations to adopt reasonable measures in addressing the environmental determinants of NCDs. In conceptualising the role of section 27 in addressing NCDs and their environmental determinants, it is important to note that it does not provide an unqualified right of access to health-care services. However, there is scope to argue that reasonable measures under section 27 could include an obligation to prevent or mitigate environmental degradation such as air pollution, and an obligation to provide reasonable treatment for NCDs caused by the state's failures in relation to its obligations under section 24.

> **...it is important to note that it does not provide an unqualified right of access to health-care services.**

## Section 24 and health

Section 24(a) of the Constitution states that '[e]veryone has the right to an environment that is not harmful to their health or well-being'. The right establishes an obligation on the state to prevent harm to health that is caused by pollution, environmental degradation or climate change. In addition, subsection(b) includes the right to have the environment protected through measures that, among others, 'prevent pollution and ecological degradation'. The environmental right is therefore critical in addressing the underlying determinants of NCDs that are caused or exacerbated by such pollution or ecological degradation. Effective realisation of section 24 would contribute significantly to the health of the population, particularly where air pollution is concerned. If the incidence of environmentally related NCDs could be reduced through the promotion of section 24, more resources would be available to contribute to the progressive realisation of access to health-care services.

As we know from section 27, the Constitution does not include a right to a certain standard of health but rather a right to have access to health-care services. While section 27 is subject to progressive realisation, the right to an environment not harmful to health is not qualified in this way. This suggests scope for more immediate obligations on the state to protect people from the health impacts of environmental harm.

The existence of the right to health-care services has implications for how section 24 is interpreted. The concept of health in the environmental right must mean more than access to health-care services which is already covered under section 27. As a result of the limited scope of section 27(1)(a), the environmental right has an important role to play in advancing health in South Africa.

It is clear that the environmental right aims to guarantee a certain quality of environment which is, at a minimum, not harmful to an individual's health. The scope and application of this right has not yet been clearly delineated by the courts. However, a handful of cases shed light on the scope of this right. For example, *Minister of Health and Welfare v Woodcarb (Pty) Ltd* (1996), which was decided under the interim constitution, confirmed that air pollution can lead to a violation of the right to an environment that is not detrimental to health or well-being. In relation to the scope of well-being, the court in *HTF Developers (Pty) Ltd v Minister of Environmental Affairs and Tourism* (2006) held that the environmental right 'does not confine itself to protection against conduct harmful to health but seeks also by, inter alia, the promotion of conservation and ecologically sustainable development, to ensure an environment beneficial to our "well-being"' (para 18).

**This is perhaps due to the more nebulous nature of 'well-being' and the existence of a separate right to health-care services in section 27.**

While other cases have relied on section 24, few have done so in relation to direct harm to health. The notion of well-being in the context of section 24 has also been the subject of greater academic interest than harm to health. This is perhaps due to the more nebulous nature of 'well-being' and the existence of a separate right to health-care services in section 27. Despite the fact that the meaning of 'health' in section 24(a) is relatively clear, 'harm to health' under the environmental right has not been a common cause of action in the courts.

There may, however, be an opportunity for clarification on the meaning and scope of section 24 in a forthcoming case brought by the trustees of groundWork trust and the Vukani Environmental Justice Alliance Movement in Action. The applicants are represented by the Centre for Environmental Rights (CER), and their notice of motion seeks, among other things, a declaration that 'the poor air quality in the Highveld Priority Area is in breach of

residents' section 24(a) right to an environment that is not harmful to their health and well-being' (CER 2020). This case, dubbed the 'deadly air' case, has significant potential to affirm the right to be protected from the harmful health effects of air pollution, including its contribution to the prevalence and severity of NCDs. It is significant that the court received submissions from the UN Special Rapporteur on Human Rights and the Environment, David Boyd, as an amicus curiae. The case was heard in May 2021, but judgment has not yet been handed down.

It is clear from the content of section 24 that the state has a responsibility to prevent and mitigate harm to health that results from environmental degradation such as air pollution. The state therefore has obligations not only in relation to the provision of health-care services and the treatment of NCDs, but also to the prevention of NCDs insofar as they are caused by a harmful environment. The section below explores the possibilities of an interdependent reading of the rights in sections 24 and 27.

## The interdependence of sections 24 and 27

The interdependence of all human rights is a central principle in international human rights law and is based on the notion that all human rights can be mutually supporting (Porter 2020: 301-3). For socio-economic rights specifically, interdependence has been utilised to support the protections afforded by these rights and develop their normative content to integrate and support other rights, such as civil and political rights (Scott 1989: 781; Liebenberg & Goldblatt 2007: 341). In the South African context, the interdependent and interrelated nature of socio-economic rights (with other rights and between different socio-economic rights) was recognised by the Constitutional Court in *Government of South Africa v Grootboom* (2001) (paras 23-24).

Prominent socio-economic rights scholars have advanced arguments on how other constitutional rights, such as the right to human dignity, equality and freedom, could be utilised interdependently to develop the normative content of socio-economic rights and the reasonableness review standard (Liebenberg & Goldblatt 2007). The Constitutional Court has also utilised interdependence in this fashion, most prominently in the case of *Khosa v Minister of Social Development* (2003). In that case, the Court found individual violations of the rights to equality and social security, but utilised equality in assessing the reasonableness of the measures to realise the right to social security. Interdependence in South African law therefore has a solid academic and jurisprudential foundation, with great potential to be utilised in future socio-economic rights cases.

Attempts to develop the interdependence of the right to health with other constitutional rights have been limited. The court in *Soobramoney* recognised the interdependence between section 27 and the right to life, but reasoned that an unqualified right cannot be used to define a qualified right. The court therefore ascribed a limited role to interdependence, one that Sandra Liebenberg has argued could have been stronger. For example, the right to life could have been utilised to examine the budgetary justifications for refusing treatment for Mr Soobramoney (Liebenberg 2016: 143-4). Marius Pieterse has also attempted to promote the interdependence of the right to health by linking it with notions of autonomy (Pieterse 2008).

The concept of interdependence between socio-economic and environmental rights is still in its infancy. There has been limited scholarship exploring

**Interdependence in South African law therefore has a solid academic and jurisprudential foundation, with great potential to be utilised in future socio-economic rights cases.**

the specific interdependence between the right of access to health-care services in section 27 and the right to an environment not harmful to health or well-being in section 24. While scholars have highlighted the interlinkages between section 24 and socio-economic rights, a number of cases have been criticised as failing to recognise or develop this interdependence. These include the missed opportunities in *Grootboom* (Fuo 2011) and *Mazibuko v City of Johannesburg* (Kotzé 2010).

> **The state's obligation in this regard is not subject to progressive realisation and should therefore be realised without delay**

The concepts of health, well-being and sustainable development in section 24 have relevance for socio-economic rights such as the right of access to health-care services, the right to sufficient water and food, and the right of access to adequate housing. Developing the interlinkages between these rights enhances their potential to address the intersecting socio-economic and environmental injustices that vulnerable groups face (Du Plessis 2011: 290-1; Murcott 2015: 879, 893). For example, addressing the health impacts of air pollution requires addressing the environmental regulation of emissions and polluting industries as well as issues of spatial injustice and access to health care.

In the case of severe air pollution, the interrelationship between the rights in sections 24 and 27 is clear. Ideally, section 24 and its subsidiary legislation would prevent harm to health that is caused by pollution and environmental degradation, thereby reducing the incidence and prevalence of NCDs linked to environmental harm. The state's obligation in this regard is not subject to progressive realisation and should therefore be realised without delay. Where there is a failure to prevent such harm to health, the state has an obligation under section 27 to address the continuing harm through access to appropriate health care.

It could be argued that the state has a greater responsibility to ensure access to health care under section 27 when the cause of the ill-health is the state's own failure to realise the right in section 24(a). Where the health consequences of air pollution persist despite a later improvement in air quality, section 27 could be utilised to ensure that NCDs resulting from environmental factors (and the state's failure to prevent resultant harm to health) continue to be treated. An interdependent reading of the two sections could therefore extend the initial obligation on the state.

Sections 24 and 27 can also be utilised to emphasise the disproportionate impact of environmental degradation on vulnerable groups. In the deadly air case, for example, the CER has pointed out that it is children, the elderly, and people with existing medical conditions who are most affected by the polluted air in the Highveld Priority Area (CER 2020). While the state should ensure that no one experiences environmental harm to health, vulnerable groups are significantly more at risk of NCDs resulting from exposure to environmental risk factors. An interdependent reading of sections 24 and 27 underscores the conclusion that, in meeting its obligations under these rights, the state should prioritise the most vulnerable groups.

## Conclusion

Given the significant risk that environmental harm poses for the incidence and severity of many NCDs, it is essential to consider the environmental dimensions of the problem alongside questions related to health care. We have proposed that a more interdependent understanding of sections 24 and 27 can strengthen state obligations related to the prevention and treatment of NCDs that are caused or exacerbated by environmental factors. In the context of NCDs, this interdependent approach underscores the following:

- the state has an obligation under section 24 to prevent NCDs resulting from environmental harm;
- the state has a particular obligation to treat NCDs where they are caused or exacerbated by its failure to prevent harm to health in accordance with section 24(a); and,

- properly preventing environmental harm will promote the effective use of state resources by avoiding the unnecessary costs associated with treating preventable diseases.

While we have focused on the problem of air pollution and NCDs, this interdependent approach is potentially valuable for any health impacts resulting from environmental harm. The interdependence of the rights to health-care services and the environment is therefore relevant for health concerns related to various environmental threats such as those arising from waste management, land contamination, water pollution, mining operations or hydraulic fracturing. In addition assisting in the identification of state obligations under section 24 and 27, this interdependence has the potential to contribute to the formulation and design of remedies in cases such as the forthcoming deadly air case, where both rights are implicated.

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EVENT

# Webinar: The Link between Access to Safe and Nutritious Food and NCDs

*Paula Knipe*

*On 18 March 2021, the Socio-Economic Rights Project at the Dullah Omar Institute hosted its first webinar in a series entitled 'Human rights and non-communicable diseases [NCDS] in South Africa'. The rise of NCDs has been described as a 'public health emergency in slow motion' and is now the leading cause of mortality in South Africa and estimated to account for 51 per cent of the country's annual deaths. These diseases have been driven by five major risk factors: air pollution tobacco use; physical inactivity; the harmful use of alcohol; and unhealthy diets. Research has shown that diet-related factors are now associated with more premature deaths than any other factor.*

This webinar explored the intersection between access to safe and nutritious food and NCDs in South Africa with the aim of sparking meaningful conversation. Given that this situation has been compounded by the Covid-19 pandemic, the webinar also sought to explore how the proliferation of NCDs has been exacerbated by high levels of food inaccessibility and weakening health systems overburdened by a welter of challenges. The webinar endeavoured to provide a platform to identify collective solutions in responding to the increase of diet-related NCDs in South Africa. Similarly, it hoped to extend the conversation to advocacy strategies and approaches to addressing this challenge.

The first panellist, Prof Rina Swart, looked at the extent of diet-related NCDs in South Africa and asked the questions, 'What is the "nutrition transition"?" and 'How are our consumption habits perpetuating NCDs?" She noted that while numerous data collection activities have been undertaken on access to safe and nutritious food in South Africa, the methodologies vary and NCDs occur among different groups, so there are many gaps in the available statistics.

She noted that the food we consume, and the consequences of this diet, form part of a complex set of circumstances which are all interlinked – known as the quadruple burden of disease. There are socio-economic factors at play including poverty, unemployment, inequality and the commercial determinants of health, which feed both undernutrition and overnutrition. These factors are also the underlying drivers of many NCDs in the South African context. Prof Swart said that 55 per cent of households are living below the upper poverty line (R1268) and 25 per cent are living below the lower food poverty line (R585). Alarmingly, even in a food-secure nation, extreme inequality is reflected in the fact that 60 per cent of the country has access to only 7 per cent of its wealth.

Between 1997 and 2012, more people died from NCDs than from HIV/AIDS. However, this does not correlate with the national budget for NCDs, and specifically diet-related NCDs, which are not receiving the attention or resources necessary in terms of the appropriate strategic response. Notably, while NCD death rates are extremely high, millions of people also live with NCDs, with Covid-19 having brought to light useful data on the extent of these co-morbidities.

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Prof Swart then contextualised the 'nutrition transition' taking place in South Africa with regard to the global epidemic that is obesity. The country is currently seeing a steep increase in the rate of obesity among men and women and, most concerningly, children. Over the last ten years, the rate of obesity in children has increased from 1 in 20 to 1 in 8. She also provided insights on the food costs, the types of foods consumed, how food is acquired, food environments and the consequences of these phenomena in terms of ill-health, diseases and death. Prof Swart emphasised the importance of strategies that target the specific issues identified, with particular intentions and outputs. Strategies should consider food-related information, advertising and the availability of certain foods.

> **Effective, transversal and inclusive food system policies are centra**

The second panellist, Dr Jane Battersby, spoke on the topic, 'The food environment in South Africa: Making the link between urban food policy and NCDs in a post-pandemic era'. Dr Battersby provided some potential urban interventions that might help address NCDs and inform the kind of food systems needed in a post-pandemic world. She noted that this is an opportunity for local government, as much of the national policy sphere is concerned with regulating health messaging and the ingredients of foods, with little consideration given to local food environments and sensitivities.

Dr Battersby provided an overview of the current food system in South Africa. There has been an increase in the expansion of large chain-supermarkets, affecting the availability of both diverse foods and more ultra-processed foods, and reshaping local economics and dietary patterns. While this is not the main cause of increasing overnutrition and ill-health, it is certainly a contributing factor. She also contextualised the food environments at a neighbourhood level, looking at factors such as infrastructure, mobility, transportation, trading bays, crime, storage facilities, sanitation, water, security of tenure and lack of support services. All of these factors intersect to shape food environments, which highlights two major issues: first, where the relative power in the food system is and where this power should be regulated, and secondly, that those shaping the food system have no interest in its outcomes. Dr Battersby noted that national and local scale policies need to be integrated as much of the contributing factors fall within the existing mandates of local government. Effective, transversal and inclusive food system policies are central in rebuilding the economy and improving public health.

The third panellist, Dr Vicki Pinkney-Atkinson, addressed the topic, 'Advocating for effective NCDs policy and implementation in South Africa: What CSOs should know'. Her presentation provided insight into the history of the SANCD Alliance, with its focus on advocacy and policy coherence in relation to equitable access to NCDs+ prevention and management and universal health care. Dr Pinkney-Atkinson shared the sentiments of Prof Swart, noting that there is an underwhelming amount of funds in the national budget for NCDs: 97 per cent of funds are devoted to communicable diseases and 1 per cent to NCDs.

> **...increase in the expansion of large chain-supermarkets, affecting the availability of both diverse foods and more ultra-processed foods, and reshaping local economics and dietary patterns.**

In terms of policy action, Dr Pinkney-Atkinson elaborated on various approaches useful for effecting policy change, looking at Kingdon's multiple stream approach and using existing benchmarks to advocate for the implementation of existing policy coherence. Given the lack of interest in and action over NCDs, the Alliance has formally laid a complaint at the South African Human Rights Commission advocating for equitable access to health care for

people living with NCDs (PLWNCDs) as well as proper implementation of the national strategic plans on NCDs.

She also shared some insights on the importance of changing the approach to health policies. There is an imminent need for a paradigm shift and doing away with silos and the misconception that there is one approach or solution to addressing the rise of NCDs. The prevention and management of these diseases require a broad approach that tackles the biological and social factors that contribute to them. There is also a need to shift the narrative surrounding the way these diseases are addressed – obesity, for instance, should be understood as a condition and not simply a 'risk factor'. It is clear that the government is failing to meet its targets, so it is the duty of civil society to hold government accountable by advocating for appropriate change.

The question-and-answer session made for thought-provoking discussion. Opinions were shared on the social stigma surrounding overweight and obesity, as well as, conversely, on the cultural norms regarding women having a well-rounded figure. The complexity of the issue was noted, as was the need to reframe the narrative. Much of the conversation centred on obesogenic environments and the many underlying food-system inequities among marginalised and under-resourced groups.

In regard to the issue of commercial baby food, it was noted that sugar and salt are learnt preferential tastes and that babies should be exposed to healthier foods. Breastfeeding is important in ensuring adequate nutritional intake for the baby, but other issues arise as well. Often too little attention is given to the mother's nutritional status, and a lot of misinformation is shared in this regard. The gendered dimensions were also debated, including social and cultural stigma and men's tangible contribution to their babies' well-being. Participants then discussed the role of dietitians, health professionals and government officials in preventing NCDs, as everyone has a role to play. Currently, there is insufficient capacity as well as a lack of resources to deal adequately with the increasing rate of NCDs – indeed, there is little political interest and will in prioritising NCDs. Consideration should be given to accurate costing, as well as to how the existing budget is rolled-out and administered.

**There is problem with basic school nutrition knowledge, which is not aligned with feeding schemes or what is being sold at tuckshops.**

There are also institutional and systemic factors which heavily influence the health system in South Africa, including previous health crises, political interests, international agendas and shifts between public and private health care. An emerging area of research was highlighted, namely the role of local government in food-sensitivity programmes. It is clear that mandate exists at municipal level that spans many areas of food governance. However, it is necessary to ascertain whether local governments are equipped to handle the responsibility, and whether national government is ready to recognise this.

The participants reflected on access to safe and nutritious food among children, looking at the role of the national school nutrition programme and the integrated school health policy. There is problem with basic school nutrition knowledge, which is not aligned with feeding schemes or what is being sold at tuckshops. While the government must be applauded for its efforts in this regard, current policies and programmes are outdated and require intervention.

Many systemic issues remain – the pandemic has not only exposed but multiplied them. However, there is more that can be done. It is crucial that a multipronged approach is taken. In addressing South Africa's challenges, much can be learnt from how other countries have successfully responded to the same issues, albeit that attention should also be given to how the issue is framed in a country-specific context.

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UPDATE:

# Report of the Special Rapporteur on Extreme Poverty and Human Rights

*Aisosa Jennifer Omoruyi*

*In his report to the Human Rights Council in June 2021, the Special Rapporteur on Extreme Poverty and Human Rights, Olivier de Schutter, highlighted the importance of realising the right to social security, which includes protection from unaffordable health care. He considered this especially important given the current economic and social crisis caused by the Covid-19 pandemic, which caught countries off-guard. The Rapporteur also acknowledged the limited fiscal capacity of low-income countries in this regard, given their high social needs yet low public revenues and insufficiency of international support.*

He recommends the establishment of a global fund for social protection to increase the level of support to low-income countries. This would enable them to set up and maintain social protection floors and improve the resilience of their social protection systems against shocks, as well as supporting increased mobilisation of domestic resources for social protection. This is in line with international standards, including the commitments of member states under the Sustainable Development Goals as well as the ILO Social Protection Floors Recommendation, 2012 (No. 202). The Special Rapporteur cited the proven economic benefits of social protection at national, household and individual levels in alleviating poverty.

In the report, the Special Rapporteur provides guidance on the structure and governance of the global fund as well as country-level coordination. Rather than creating dependency on international support, the initiative is aimed at matching international support with the domestic efforts of countries that are committed to the establishment of social protection floors and whose ability to finance social protection would improve in time with relevant reforms.

Although non-communicable diseases (NCDS) are traditionally seen as diseases of affluence, research demonstrates that they strike along the fault lines of social inequality, given the dual causal relationship between poverty and health. Poverty contributes to the risk factors for NCDs, such as unhealthy diets and difficulties in accessing adequate health care upon the onset of any chronic NCD. Health inequalities extend beyond the inadequacies in the health sector and gaps in social health protection coverage. Indeed, social, and economic inequalities outside the health sector itself create barriers to accessing affordable health-care services for those living in poverty.

In addition to their social and economic benefits, such as income security, national social protection floors are intended to have a positive and equitable effect impact on health outcomes. This not only means improved and equal access to health care but also entails strategies for the prevention of ill-health. International cooperation and assistance aimed at low-income countries would assist in the realisation of the right to health and prevent and manage NCDs, which are a growing challenge in low- and middle-income countries. Such an intervention would be useful in addressing the link between poverty and health by ensuring affordable access to health care and maintaining a productive workforce.

To view the report, click here: ***https://undocs.org/A/HRC/47/36.***

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