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The International Journal of Human Rights

ISSN: (Print) (Online) Journal homepage: https://www.tandfonline.com/loi/fjhr20

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To cite this article: Safura Abdool Karim & Bonginkosi Shozi (2023) Is a right to health a means to protect public health? South Africa as a model for a communitarian interpretation of the right to health for the promotion of public health, The International Journal of Human Rights, 27:5, 925-949, DOI: 10.1080/13642987.2023.2190584

To link to this article: https://doi.org/10.1080/13642987.2023.2190584

Published online: 24 Mar 2023.

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THE INTERNATIONAL JOURNAL OF HUMAN RIGHTS
2023, VOL. 27, NO. 5, 925–949
https://doi.org/10.1080/13642987.2023.2190584

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Is a right to health a means to protect public health? South Africa as a model for a communitarian interpretation of the right to health for the promotion of public health

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ABSTRACT

The right to health has primarily been developed and understood as an individualistic right and framed in terms of healthcare services. Public health and disease prevention have become increasingly important, particularly with the increasing occurrence of novel pandemics. The ability of the traditional framing of the right to health is less helpful in contexts where one seeks to apply a human rights-based approach to public health interventions. Though it has been posited that this may be remedied through the introduction of a collective right to public health, the South African experience illustrates the potential of the existing right to health to support public health e□orts. Drawing on the African concept of 'ubuntu', one can adopt a communitarian approach to the right to health to enforce and protect the right, even where identifying discrete rights-holders and beneficiaries is challenging. This paper further argues that this communitarian approach to the right to health can ameliorate some di□culties experienced with judicialisation of health in other jurisdictions. The South African experience of judicial enforcement of the right to healthcare is used to illustrate the potential value of utilising a communitarian approach to the development of the right to health to include public health.

ARTICLE HISTORY
Received 24 February 2022
Accepted 23 February 2023

KEYWORDS
Right to public health; disease prevention; human rights; collectivist rights; communitarian

1. Introduction

> Without public health and the lives it protects and promotes, no other rights would be possible. Whether caused by an individual lack of curative care or a collective lack of public health, the resulting morbidity and mortality su□ered represents a gross violation of human rights. Public health is a vital component of health rights, without which states could not assure the health of individuals.[1]

Since it's codification in the 1946 Constitution of the World Health Organisation, the right to the 'highest attainable standard of health', in the form of a right to health has

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increasingly gained recognition in domestic constitutions. Alongside this recognition, there have been debates as to whether the scope of the right is limited to medical treatment and healthcare services,[2] or if it includes the broader antecedents of good health (also referred to as the social determinants of health),[3] such as those enumerated in the right to 'a standard of living adequate for … health and wellbeing' articulated in article 25(1) of the Universal Declaration of Human Rights.[4] While much attention and focus has been placed on defining the entitlements this right affords in the way of individual access to healthcare services, less has been given to the relationship between the right to health and public health. The right has, in this regard, been framed almost entirely in terms of individual entitlements and the duty placed on the state.

Unlike with individual access to healthcare services, public health efforts are more diffuse in nature. Rollinson posits that public health 'refers to disease prevention and health promotion at the level of the collective.'[5] Interventions underlying public health efforts are often preventative, population level interventions that may lie outside the healthcare system.[6] In resource constrained settings, interventions can often play a pivotal role in the protection and indirect realisation of the right to health by reducing the burden diseases place on the healthcare system.

The role of public health has become increasingly important in the realisation of the right to health, particularly with the increased frequency of novel pandemics where population level interventions operate to protect collective health and it is challenging to identify the individual rights-holders that benefit from these actions. In these scenarios, the nature of public health, and its interaction with the right to health, is distinct from the individual treatment usually contemplated as part of a right to health and healthcare. Mason-Meier and Mori, in their discussion of a 'right to public health' elaborate on this, postulating that public health interventions offer an efficient means for realising the right to health, particularly in resource-constrained settings.[7] In this sense, public health interventions may yield greater benefits and satisfy duties of progressive realisation and minimum core under the right to health when compared to access to individual medical and healthcare services.[8]

There is an additional component to the distinction between improving public health versus individual healthcare in the context of novel pandemics. The public health response to novel or emerging pandemics is often unable to rely on biomedical interventions, and instead relies on non-pharmaceutical interventions (NPIs) that often lie outside the healthcare system.[9] These epidemic control interventions operate on a population level, and protect public health in a way that makes discerning discrete beneficiaries of the intervention – and correspondingly rights-holders – complex if not impossible, particularly where these interventions cannot absolutely prevent a disease but contribute to a reduction in the burden.[10] Yet it is recognised that a rights-based approach to these public health efforts is central to their success.[11] As Mason-Meier & Mori outline, the emphasis on individualistic interpretations have overlooked the potential for the right to health to improve public health and in doing so, vindicate the right to health at a community level:

> Applying only a curative health model to societies under the individual right to health has denigrated collective responsibility for health, relegating obligations for healthy conditions to the individual alone. Yet, to the degree that the right to health, like all individual rights, is

> premised on the autonomy of the individual, globalization's autonomy-diminishing e□ects impair an individual right to health and necessitate a collective approach to health rights.[12]

In pandemic responses, there is a need to develop the role of rights beyond impediments to the measures to a mechanism to buttress and guide epidemic responses.[13] During the COVID-19 pandemic, many NPIs which limited individual rights – such as isolation and quarantine, restrictions on movement and gatherings, and mandatory mask-wearing, were central to the pandemic response.[14] There was opposition to these measures and the ensuring curbing of individual rights in many countries, which may be addressed through framing rights as supportive public health measures.[15] Thus, the development of a right to public health – or the application of the right to health to public health interventions, can o□er value for both pandemic responses as well as broader public health e□orts.

Despite the importance of having rights underpinning public health responses, there is lack of literature on this right to public health and how the right to health can support public health e□orts. There has not been much development of the concept in scholarship beyond Mason-Meier & Mori's treatise on the need to create a right to public health.

Practically, however countries and judiciaries have been required to address tensions between public health and rights. In doing so, these bodies have had to considering the role of rights in public health responses and developed conceptual approaches to this issue – including how to use rights to buttress population-level interventions.

A potential means to address this lacuna in international law emerges from South African jurisprudence. Section 27(1)(a) of the South African Constitution[16] is often understood to be a domestic analogue for the right to health[17] and provides:

> Everyone has the right to have access to— health care services, including reproductive health care[18]

The language of section 27(1)(a) emphasises, in the first instances, 'access' and in the second instance to 'healthcare services' being biomedical interventions and treatment of disease. On the face of it, the section frames the right as an individual's entitlement to medical treatment. Yet the interpretation given to section 27(1)(a) by the courts, and the framing of a rights-based approach to public health in South Africa jurisprudence, conceptualises section 27(1)(a) which both provides an entitlement to treatment as well as a right which protects, and promotes public's collective interest in health. What enables this collectivist entitlement to health is a communitarian interpretation of an individual right which underpinned by the concepts of ubuntu and communitarianism that proliferate African traditions of human rights. This form of interpretation o□ers a mechanism to realise a right to public health within the existing architecture of the right to health adopted in so many countries. This provides the needed 'right to public health' as a concept and entitlement housed within the right to health as it currently exists and without the need to create novel human rights mechanisms to protect community-level health.

This paper proposes to use of a communitarian approach to interpreting the right to health to promote public health, drawing on the models of interpretation adopted in South Africa as a mechanism to develop a 'right to public health'.

This paper will first discuss the relationship between human rights and public health to provide scholarly context and background to the shift in framing of this paradigm. Thereafter we will canvass the differing conceptualisations of a right to public health, from the collective right proposed by Mason-Meier & Mori to the application of a communitarian framing of the right. There will then be a brief discussion of the phenomenon of judicialisation of healthcare to further illustrate the merit of the South African approach, before moving to an in-depth analysis of the communitarian interpretation of the right to health adopted in South African jurisprudence. The paper will then conclude by drawing out the form of a right to public health from South Africa as a potential guide for the adoption and interpretation of a right to public health in other jurisdictions.

2. The right to health under international law

The Preamble of the Constitution of the World Health Organisation (1946) recognised that 'the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being'.[19] The Preamble also codified a broad definition of health which extended beyond the absence of disease to include 'complete physical, mental and social well-being'. These statements amounted to the first recognition of a right to health, and even this early conceptualisation spoke of a broad right but one that was individualistic in its conceptualisation.

Two years later, the Universal Declaration of Human Rights (UDHR) entrenched this right as one that not only encompassed health and physical well-being by adopting a social determinants of health (SDOH) framing to the right.[20] Article 25 reads:

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

Article 25 recognises that a person's health is constituted by more than just physical well-being and access to healthcare services yet it remains framed as an individual entitlement to health and well-being, not a collective entitlement to broader public health.

Since 1948, there has been increasing recognition that extra-sectoral factors have a significant influence on the health and well-being of individuals, directly impacting an individual's ability to realise their right to health.[21] For example, article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR),[22] read with General Comment 14,[23] remains among the most comprehensive statements on the right to health and its content. The text of article 12 mirrors the wording of the WHO Constitution in outlining the right to health as 'the right of everyone to the enjoyment of the highest attainable standard of physical and mental health'. Sub-section 2 of the article outlines in greater detail the obligations of a state in fulfilling this right which include both the provision of healthcare services as well as obligations to 'prevention, treatment and control of epidemic, endemic, occupational and other diseases'.[24] These obligations are subject to progressive realisation and the States obligations in this regard are constrained by available resources.

The framing of these obligations focuses more on individual access to healthcare services, health outcomes and disease than on utility of population-level health

interventions or environmental factors which have a significant bearing on the realisation of the right to health. However, the Comment acknowledges article 12 is intended to capture a broader definition of the right to health which includes 'conditions in which people can lead a healthy life'.[25] Notwithstanding the adoption of this expanded conception of the right to health, the General Comment does contain caveats, acknowledging that a state cannot completely or fully ensure the good health of its citizens since illness may be the result of genetic factors or an individual's lifestyle.[26] In this regard, ICESCR's framing of the right to health includes broader public health content but places significant emphasis on the individual entitlements that make up the right to health.

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

> The Conference strongly rea□rms that health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector.[27]

Specifically, the Declaration recognised that economic and social development were required for the 'fullest attainment of health for all and [for] the reduction of the gap between the health status of the developing and developed countries'.[28]

In 1986, the Ottawa Charter for Health Promotion (the Ottawa Charter) built on this multi-sectoral approach and made it central to the realisation of the right to health, stating '[h]ealth is a positive concept emphasising social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy lifestyles to well-being.'[29] The Ottawa Charter went further, outlining in concrete terms 'prerequisites for health' which included many underlying determinants of health such as food, shelter, education and equity.[30] The Ottawa Charter specifically held these to be 'the fundamental conditions and resources for health' and went further to emphasise the role of SDOH and underlying determinants of health: 'Political, economic, social, cultural, environmental, behavioural and biological factors can all favour health or be harmful to it'.[31]

In contrast to the more expansive definitions outlined above, treaties specific to the rights of vulnerable populations have often adopted a narrower conceptualisation of the right to health. The Convention on the Elimination of All Forms of Discrimination Against Women,[32] which specifically applies to women's HR, outlines a state's obligations regarding health under article 12 as consisting of the elimination of discrimination against women to ensure equal access to healthcare services for men and women.[33]

The Convention on the Rights of the Child[34] contains both obligations and entitlements in relation to the right to health, as well as the provision that some rights may be limited in the interests of public health.[35] Article 24 recognises the rights of children 'to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health', and specifically places an obligation

on the state to ensure that children are provided with access to healthcare services, including treatment and preventative services.[36] Article 24 goes further than this, though: sub-article 2 requires states to 'pursue full implementation' of this right to health by, inter alia, providing healthcare and medical assistance as well as combatting disease and malnutrition.[37]

As outlined above, the various paradigms and definitions of the right to health contained in international law show that there is a basis for the right to health to include obligations, duties and content that extend beyond access to healthcare services and encompass the protection and realisation of the underlying determinants of health. However, there is not a specific or explicit provision for the right to health to operate at a population-level or for entitlements to be held collectively when it comes to broader public health outcomes. Rather the content as currently framed largely focuses on the duties the State owes to individuals as rights-bearers.

3. The relationship between public health and human rights – a series of shortcomings

The relationship between the right to health and public health itself is of increasing importance given the growing recognition of a right to healthcare, particularly the growing recognition of a justiciable right to health, in domestic law.[38]

The tensions that arise within this relationship may be understood by contrasting, at an ideological and conceptual level, the fundamentally collectivist aims of public health against a traditionally individualistic model and conceptualisation of human rights.[39] Human rights are often conceptualised and understood as individual entitlements and, the enforcement of these rights, particularly through the judicial system, is often through the lens of individual litigants seeking to vindicate those individual entitlements.[40] The collectivist conceptualisation of rights, and collectivist interests as a necessary antecedent to the protection of individual rights are often absent from human rights treaties that position rights as individual entitlements and the state as bearer of the corresponding obligation.[41]

The highly individualistic focus of ordinary human rights discourse was captured in Elliot's contention that the increasing global adoption and acceptance of human rights is 'the triumph of the individual'. To this end, Elliot asserted that, 'the normative content of human rights standards points to a global environment where the individual is widely regarded as fundamentally sacred and inviolable, and therefore the locus of rights that must be guaranteed by legitimate global actors.'[42]

However, against this understanding of individual entitlement, the inherently collective goals of public health initially seem incompatible with the rubric of individual human rights. Indeed, for much of history, public health e□orts have been pitted as infringing, limiting or disregarding an individual human rights in furtherance of this collectivist notion of 'public health'.[43] Even the recognition and the accompanying judicialisation of a justiciable right to health in certain settings has been viewed as exacerbating inequities by realising the right to health of individual litigants at the cost of resources being allocated to the collective.[44]

A further challenge presented by individualistic interpretations of the right to health is judicialisation of healthcare, being 'the use of legal actions and rights-based injunctions

to obtain medical treatments and pharmaceuticals' and has led to healthcare priorities being determined by courts and litigation.[45] As an enforceable and justiciable right to health has gained increasing recognition in domestic legal systems, it's enforcement through the judiciary and court system has often driven the discourse and development of the right.[46] In particular, the extensive cases concerning access to medicines in South America have come to dominate scholarship on enforcement of the right to health.[47] Even in South Africa, a significant proportion of literature on the right to health is focussed on access to medicines as the touchstone for judicial enforcement of the right to health.[48]

This judicialisation is often framed as having negative consequences for the healthcare system.[49] In many jurisdictions with justiciable rights to health – in South America particularly – the increasing judicialisation of the right to health has seen healthcare priorities be dictated by the judiciary and individual courts cases.[50]

Though there are debates and differing accounts of the true impact of this judicialisation on equity and the healthcare – most have viewed the phenomenon as increasing the individualisation and pharmaceuticalisation of healthcare services, in many instances, skewing resources to the few individuals vindicating rights through the court system rather than the society collectively.[51] This phenomenon has seen litigants increasingly rely on the judicial system to adjudicate the realisation of a range of socio-economic entitlements, requiring courts to act as arbiter and determiners of inherently polycentric decision-making.[52] The judicialisation of healthcare within resource constrained settings, such as the Global South, carries with it unique features.[53] The increasing phenomenon of judicialisation of healthcare, specifically through the right to health, in South America has typically been accompanied by the increased pharmaceuticalisation of healthcare, emphasising access to individual treatment.[54] This exacerbates the incompatibility between the individualistic models of realisation of the right to health and a community focused-public health response that often relies on non-pharmaceutical interventions.

As a result, the use of the right to health to support the adoption of interventions that sit outside the healthcare system, is at odds with this model of enforcing the right to health and thus, there is a need for a solution to these shortcomings in the existing models of defining the right to health. In this regard, a collectivist approach to application and development of the right to health offers a solution.

It is in this context, that the creation of a right to public health or the integration of public health goals in the existing rubric of human rights, can provide a mechanism to address these challenges, tensions and shortcomings. The question is then, how should such a relationship be created? Is there a need for a new, collective right to public health, or can existing human rights be developed to include these concepts. A potential answer to this is proposed by Mason-Meier & Mori in the creation a collective right to public health. We treat this as a point of departure for the communitarian approach and thus first discuss this proposed collective right to public health.

3.1. A proposed collective right to public health

> Securing population health is not merely the health of many individual persons, but a collective "public" good that is greater than the sum of its constituent parts.[55]

Mason-Meier and Mori contend that what they describe as a 'collective right to public health' is necessary to protect, vindicate and realise a right to health in an era of globalisation.[56] The necessity of this collective right to public health is underpinned by two features of this increasingly globalised world. The first is that individual medical care – and the corresponding rights that protect this such as a right to healthcare or access to medicines – are less relevant to a person's health status.[57] Individuals exercise less control over their own health status but instead, 'underlying societal determinants of health' have an increasing influence on individual health.[58] These features mean that the controlling epidemics requires require the adoption and implementation interventions that lie outside the healthcare system, tackling the social determinants of health such as gender, education, food and development.[59] In fact, in many instances, measures that seek to address epidemics are population level interventions that do not per se have direct and identifiable beneficiaries. Within legal discourse, there is often then an inherent tension between these population level interventions and their impact on individual rights as they are traditionally construed. This tension emanates from the framing of public health e□orts as resulting in incursions on individual rights, which itself is a product of the construction of rights in a manner divorced from broader public interests. Little to nothing is said of the communal interests that may be protected by public health interventions, and how health rights relate to these interests.

At a conceptual level, this may be due to the scope, and expressly individualistic definitions of human rights under international human rights instruments.[60] At a practical level, this may be informed by the development and enforcement of rights through litigation which operationally requires individual right holders to bring the case but cannot accommodate or concretely recognise individual right holders benefiting from population level public health interventions. At an ideological level, Mason-Meier & Mori argued that the Western notions of negative obligations as the centre point for enforcement of rights have excluded a collective right to public health from the ambit of the existing right to health. This may emanate an initial emphasis on civil and political rights which are negative in nature. Collectively, these three facets may have fuelled what Mason-Meier & Mori suggest is an undue focus on individual access to healthcare as the core content of this 'atomised right to health' which has skewed the focus of action on health to focus on the healthcare system over other interventions:

> The right to health has been advanced in the ICESCR as an individual right, focusing on individual access to health care at the expense of collective health promotion and disease prevention programs. … Despite developments in public health since the original drafting of the ICESCR, the right to health remains mired in a curative or clinical model of health, quixotically advancing individual medical solutions to problems requiring societal change through public health programs. … Thus, while public health has developed to meet changing health needs, the right to health has not evolved to meet this changing conception of health.[61]

Centrally, Mason-Meier and Mori contend that the content of the existing right to health cannot accommodate a right to public health but instead, a right to public health requires the creation of a complementary but independent societal right to public health. Though we agree that legal recognition to the collective interest in public health is of immense value, we disagree with the proposition that this can only be achieved through a novel 'collective right to public health'. The notion of a collective right to public health as a

solution faces challenges including that fact collective rights are not universally accepted. Beyond this, the right to public health potentially has the same weakness as a right to health, namely: a dischotomised conceptualisation of health that fails to recognise that health interventions are both fundamentally a public issue as well as a deeply individualised and personal one. As an alternative, this paper seeks to argue that a communitarian interpretation of the right to health can provide a basis for recognising, protecting and vindicating public health. This approach is expanded upon in the next section.

3.2. An alternative approach: the case for a communitarian approach to the right to health

What is apparent from the preceding discussion is that public health objectives are confounded by the right to health because of the individualistic way rights tend to be interpreted.[62] This issue is, however, a direct consequence of the Western account for human personhood and rights. But this issue does not arise if personhood and rights are conceptualised in a di□erent way, as is the case in certain streams of thought of African philosophy, including African communitarianism. African communitarianism is characterised by the view that the individual, and any entitlements they may have, are inextricable linked to the interests of the broader community.[63] As John S Mbiti puts it, communitarianism is founded on the premise that 'the individual does not and cannot exist alone except corporately [because] [h]e owes his existence to other people'.[64]

From the perspective of African communitarianism, all individuals within a community share a dialogical relation, and because of this, they also share reciprocal obligations to each other, chief which is the duty to treat others in a way that promotes harmony in the community.[65] As a result of this, no individual's entitlements can ever be conceived of in a way that is adverse to the interests of the broader community. This is something which South African courts, in particular have recognised in recent years, in departing from the atomistic view of the person and their entitlements, to a view based on communitarianism – as Forman explains:

> [T]his approach to rights was based on the traditional African notion of 'ubuntu', which translates to 'humaneness', personhood and 'morality', and which 'envelops the key values of group solidarity, compassion, respect, human dignity, conformity to basic norms and collective unity.' This is a notion which the Court argues 'su□uses the whole constitutional order … . [and] combines individual rights with a communitarian philosophy.' This approach to rights seeks to ensure not simply that individual rights are realized, but to make doing so an integral part of a collective ethos of mutual respect and humaneness.[66]

The concept of 'Ubuntu' alluded to above is descriptive of an underlying ethos of sub-Saharan African cultures, which holds that all human beings, being inherently social creatures, require other human beings in order to live a good life. Therefore, individuals in a community owe reciprocal obligations to each other aimed at achieving harmonious relations within society.[67] This ideology is associated with the Nguni expression 'umuntu ngumuntu ngabantu', which may be translated as 'persons depend on persons to be persons'.[68] One might assume that communitarian philosophy like Ubuntu, and its regard for the interests of the broader community, is entirely opposed to the idea of individual human rights. However, as commentators on Ubuntu have pointed out, any claims of a disjunction between human rights and African communitarianism are a

product of a misrepresentation of rights as being exclusively a feature of individualism and a manifestation of the atomistic view of the human person in Western philosophy.[69] However, as alluded to above, the e□ect of Ubuntu has not been to reject the concept of individual human rights, but to redefine rights in a way that reflects the African communitarian vision of the individual person as an entity indelibly bound to, and in a dialogical relations with, a broader community. This is what was meant by Sachs J remarked that Ubuntu 'combines individual rights with a communitarian philosophy'. Accordingly, a trend that has emerged from the interpretation of rights through the lens of Ubuntu is an acknowledgement of the need for individual autonomy to not be framed in an atomistic and overtly individualistic way.[70] It is this reconceptualisations of how one thinks about individual rights, which we seek to argue for in the context of the right to health in this paper.

The reason African communitarianism is a worthwhile lens through which to view the right to health, is because of how it provides a useful means through which to navigate the apparent conflict between this right and the society's collective interest public health. This conflict is, in e□ect, a conflict between the interests of particular individuals and the interests of the broader community. And what we see in cases dealing with conflict between the interests of individuals and communities in which Ubuntu is utilised, is that what African communitarianism calls for is not a dominance by community or individual, but a recognition of their interrelated relationship.[71] A similar approach can (and should) be taken at a global level in relation to the right to health, especially in regards to health interventions that have implications for both individuals health outcomes, as well as the health of the general public. It is for this reason we argue for a communitarian approach to the right to health, which, as Langa J puts it, 'calls for a balancing of the interest of society against those of the individual'.[72]

As a means of expanding on the argument for a communitarian approach to conceiving of the right to health, the next section outlines the relationship between ubuntu and the African human rights system before turning to consider South African jurisprudence as an example of how such an approach may be operationalised.

4. The regional approach: the African human rights system, the right to health and ubuntu

4.1. The right to health under regional instruments

At a regional level the right to health has, notwithstanding the narrower text contained in key instruments, the developed a scope that extends beyond access to healthcare. The African Charter on Human and Peoples' Rights (the African Charter),[73] recognises the right to health in Article 16 as the right of every individual 'to enjoy the best attainable state of physical and mental health'.[74] The article outlines the specific obligations states have with regard to the fulfilment and realisation of the right to health, stating: 'State parties to the present Charter shall take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick'.[75]

Despite expressly outlining the core obligations in relation to medical attention, subsequent interpretation of the article has seen the text imbued with a broader meaning. In Social and Economic Rights Action Centre and another v Nigeria,[76] the Commission

recognised a right to food as being implicitly contained in both article 4 (the right to life) and article 16 (the right to health) of the African Charter.[77] The Commission explicitly recognised a conceptualisation of the right to health, owed to a community, that was contingent upon the enjoyment of other rights:

> While the right to food is not specifically enumerated in the African Charter, it is implicit in such provisions as the right to life (art.4), the right to health (art. 16) and the right to economic, social and cultural development (art. 22) … It is undeniable that food is central to the enjoyment of such other rights as health, education, work and political participation.[78]

This solidified the content of article 16 as expanding beyond individual access to healthcare to a broader entitlement a□orded a community a□ected by the activities of a private actor.

The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (the Protocol)[79] provides special protections to women, specifically to protect women against discrimination. Article XIV of the Protocol contains a right to health, specifically related to sexual and reproductive health The Protocol also requires states to take action to curb 'harmful practices', including practices which, inter alia, negatively a□ect a women's rights to health, dignity and physical integrity.[80] Though the content of the entitlements contained in the Protocol are broader, the enforcement and framing of duties remains highly individualistic in its content.

Under article 14 of the African Charter on the Rights and Welfare of the Child (African Children's Charter),[81] all children have the right to enjoy the best attainable state of physical, mental and spiritual health. Article 14.2 outlines a state's obligations under this right and includes specific measures to protect this right. Specifically, states are required to 'to ensure the provision of necessary medical assistance and health care to all children' and are obligated to take steps to assist parents to realise these entitlements as well.[82]

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

4.2. Ubuntu and the African human rights system

The African Charter has adopted a collectivist and communitarian approach to the content of the rights it protects. The principles of communitarian were to be borne in mind from the development of the Charter and particular emphasis was placed on the protection of socio-economic rights, not just individualistically but collectively.[83] This is done most overtly in those rights which are explicitly created as collectively held rights, such as the right to development or the nature of the right to property where it is held by communities rather than individuals.[84]

However, the Charter e□ects the communitarian approach even within the other rights through its inclusion of collectively health 'people's rights' as well as its inclusion of duties on individuals as well as states.[85] Under Article 27, individuals have rights to their families and society as well as to the State. Moreover, when exercising one's

rights, one must have due regard to the rights of others as well as community or public well-being in the concepts of 'common interest' and 'collective security'.[86] These two components reflect the core of a communitarian approach to human rights – illustrating the reciprocal nature of rights and duties as well as the reciprocity underlying all relationships.[87] Cornell posits that these features of the Charter as 'concrete manifestations of ubuntu'.[88] However, the concept of ubuntu within the Charter extends beyond the content of the rights to the approach adopted in understanding the relationship between rights. Communitariniasm, particularly when viewed through the lens of ubuntu, highlights the interdependence between individuals and community. Critically, it is understood that individual rights cannot 'be meaningfully exercised in isolation of broader community rights.'[89]

The African human rights system is, in many ways, anchored in the protection of peoples' and human rights and has been implemented at a country-level through the adoption of similar rights in national constitutions.[90] The next section considers how the African communitarianism has operated at a practical level and in the context of the right to health by considering how concepts of communitarianism has influenced South Africa's jurisprudence on the right to health.

5. The influence of the communitarian approach the development of the right to health in South Africa

South African case law on Ubuntu provides a practical context within which we can consider the practical implications of African communitarianism in human rights discourse. Since its inclusion in the Interim Constitution in 1993,[91] Ubuntu has featured prominently in South African law as a value that guides the application and interpretation of human rights.[92] And one recurring role of Ubuntu in South African case law has been to bring attention to the reciprocal nature of human relations in a society defined by a communitarian ethic like Ubuntu, and the implications of communitarianism philosophy for how we understand human rights.[93] This sentiment was concisely expressed by the Constitutional Court by Sachs J in Port Elizabeth Municipality v Various Occupiers:

> The spirit of ubuntu, part of the deep cultural heritage of the majority of the population, su□uses the whole constitutional order. It combines individual rights with a communitarian philosophy.[94]

The developing South Africa's jurisprudence on the right to health demonstrates how the philosophy of ubuntu may be operationalised in the interpretation of the right to health. Moreover, the South African jurisprudence provides examples of how the application of communitarianism to a traditionally individual right may work towards the protection of public health.

5.1. The initial approach to judicial enforcement of the right to healthcare

South Africa's initial judicial enforcement of the right to healthcare was characterised by two features – first, was a judicial deference to government decision-making about the provision and non-provision of healthcare services and second, that the enforcement

of rights was not individualistic. The first emphasised the separation of powers adopted by the judiciary when enforcing socio-economic rights more generally.[95] There was a recognition in early case law that the government had limited resources and that decision-making in the healthcare and other sectors was inherently polycentric.[96] This approach was adopted in the earliest of South Africa's socio-economic cases – Soobramoney v Minister of Health.[97]

However, it is in the approach adopted to interpretation of the right to healthcare that these decisions laid the foundations for an approach that would depart from the trends of judicialisation of healthcare. The earliest right to healthcare decisions are characterised by a communitarian approach to the interpretation of health rights, as evident by the court's regard on the impact the application of these rights would have on all rights bearers. As Forman put it:

> While [Soobramoney] appeared to reject an enforceable individual right to access health care services, the Court was careful to suggest that this right was in fact justiciable, albeit within a novel rights tradition premised not on autonomy but on human interdependence. This new approach would require adapting traditional rights analyses to "provide a broad framework of constitutional principles governing the right of access to scarce resources and to adjudicate between competing rights bearers."[98]

The communitarian interpretation and enforcement of the section 27(1)(b) (and related rights) adopted by the Constitutional Court remains a unique feature of South Africa's enforcement of the right to health. The South African approach remains disparate to the trend of individualistic interpretation of the right to healthcare observed in South America. As Rajan observes in his discussion of the South African model:

> South Africa has emerged as an exemplary locale for the manifestation and shaping of this phenomenon, in ways that have exceeded mere contractual dispute in order to adjudicate fundamental ethical, moral or constitutional principles, often taking recourse to discourses of rights. The judicialization of health is part of a more general contemporary global Southern phenomenon of the judicialization of politics.[99]

As will be discussed further below, the communitarian interpretation in South African right to health cases, builds a foundation upon which one can understand the content of the right to healthcare as not only owing to individuals seeking to enforce the right but as containing entitlements owed to the broader community and public – in some senses related to the protection of this broader societal entitlement to access healthcare which has been interpreted as including preventative measures. We unpack the scope of this so-called communitarian approach with reference to South African jurisprudence in the next section.

5.2. The development of a communitarian approach to a right to healthcare in South African jurisprudence

As mentioned above, Soobramoney is the natural starting point in understanding and analysing South Africa's right to health jurisprudence. As a case concerning the enforcement of an individual's right to dialysis treatment, the court may have elected to enforce that right as an entitlement owed to the applicant alone or to the group of individuals in the same medical position as the applicant. Instead, the court elected to balance the right

of the applicant and those in his position to healthcare against the interests in public health of broader society. This position was articulated by the framing of the competing interests by Chaskalson P as the impact provision of these dialysis treatment services may have on the provision of other healthcare services or even services outside the healthcare sector, particularly in South Africa's resource constrained setting.[100]

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

Here, Chaskalson was particularly mindful of the impact a claim such as the applicant's may have on the healthcare system that is utilised by the broader South African population.

The hallmark of judicial deference in socio-economic cases was not solely framed as an issue of poly-centric decision-making or allowing the State to make decision but framed far more collectively as a concern about the rights and entitlements of those not immediately before the court. In Chaskalson's discussion of resource constraints he explicitly considered how this decision may impact the broader needs of South African society, stating:

> Unfortunately, this is true not only of the appellant but of many others who need access to renal dialysis units or to other health services. There are also those who need access to housing, food and water, employment opportunities, and social security. These too are aspects of the right to
>
> " … human life: the right to live as a human being, to be part of a broader community, to share in the experience of humanity." The State has to manage its limited resources in order to address all these claims. There will be times when this requires it to adopt a holistic approach to the larger needs of society rather than to focus on the specific needs of particular individuals within society. [Own emphasis added.][101]

Though this is framed in terms of resource constraints, it is worth noting that in his concurring judgment, Sachs J draws out the communitarian interpretation beyond this. Though initially Sachs recognises the integral role of rationing to the protection, promotion and realisation of human rights,[102] he expands the concept to explicitly frame rights as collectively held, shared entitlements and a courts role as not only to limit rights in resource constrained settings but instead to support action which enables the greatest and more e□ective enjoyment of rights:

> Traditional rights analyses accordingly have to be adapted so as to take account of the special problems created by the need to provide a broad framework of constitutional principles governing the right of access to scarce resources and to adjudicate between competing rights bearers. When rights by their very nature are shared and inter-dependent, striking appropriate balances between the equally valid entitlements or expectations of a multitude of claimants should not be seen as imposing limits on those rights (which would then have to be justified in terms of section 36), but as defining the circumstances in which the rights may most fairly and e□ectively be enjoyed.[103]

The court's duty in relation to these rights, and thus the content of the entitlements of these rights are not owed exclusively to those seeking to vindicate their rights in an immediate court case but are a di□use, collectively held entitlement and thus actions must aim to also protect the collective entitlement to public health, rather than just the rights of those before the court.

This framing of the individual entitlements under section 27 against a broader societal entitlement to access health was reiterated in TAC, where the court stated:

> It should be borne in mind that in dealing with such matters the courts are not institutionally equipped to make the wide-ranging factual and political enquiries necessary … for deciding how public revenues should most e□ectively be spent. There are many pressing demands on the public purse. As was said in Soobramoney:
>
> The State has to manage its limited resources in order to address all these claims. There will be times when this requires it to adopt a holistic approach to the larger needs of society rather than to focus on the specific needs of particular individuals within society.[104] (emphasis added.)

In TAC, the court considered the flipside of this issue, noting the substantial e□ects the HIV pandemic could have on the achievement of other rights while acknowledging as in Soobramoney that government also faces demands to meeting obligations to access, inter alia, education, housing, water and food.[105] Consequently, the foundation for a communitarian interpretation of the right to healthcare became entrenched in the most foundational of section 27(1)(a) jurisprudence.

The preliminary exploration of judicial reference to the right to health above illustrates how the communitarian approach to the right to health has a distinct advantage to how the right is traditionally framed at the international level; namely: it reconciles the apparent conflict between individual and collective entitlements by accommodating both and balancing them.

The application of section 27(1)(a) to non-pharmaceutical interventions and public health responses more broadly has expanded over time and o□ers further detail on how this collectivist approach may be applied outside the healthcare system.

In 2009, British American Tobacco (BAT) challenged the constitutionality of the Tobacco Products Control Amendment Act 63 of 2008, specifically the sections which prohibited the advertising of tobacco products on the grounds that the ban unjustifiably limited BAT's right to freedom of expression under section 16(1) of the Constitution. It is worth noting, when considering this case, that the intervention under consideration (namely marketing restrictions) lay wholly outside the healthcare sector. In considering whether the limitation of this right was justifiable, Phatudi J gave significant weight to the public health purposes of the ban which extended beyond tobacco users to 'passive smokers', stating:

> I am of a strong, view that protection of 'public health interest' is one of the fundamental rights that override the interest of an individual including that of the applicant The right to freedom of expression is not absolute and cannot override the interest of the democratic society. Advertising of a tobacco product is made solely for the interest of a person with a sole purpose of persuading or enticing members of the public to patronise the product. In fact, the main purpose of advertising tobacco product is to promote the use of the harmful product which often becomes fatal even to the consenting adult tobacco consumers. The

> tobacco is more harmful to passive smokers especially children who find themselves, without choice, in motor vehicle(s) in which a smoker is a passenger and smoking.[106]

Despite the recognition of this 'public health' objective as a basis to justify the advertising ban, the High Court did not expressly invoke a rights-based approach to justifying the ban.

The Supreme Court of Appeal, however, approached the limitations analysis with reliance on both section 24 and section 27. The majority judgment of Mthiyane DP, focussed primarily on the public health objectives behind the advertising ban with references to both sections 24 and 27 of the Constitution. The court explicitly linked the public health objectives of the ban to the right to a healthy environment, stating: 'The public health considerations and the countervailing right to a healthy environment make a strong case for the limitation of the right which the appellant seeks to enforce.'[107]

In determining the constitutionality of a ban on the advertising of tobacco products, recognised the role of the ban in protecting public health.[108] Specifically, the Court found that government had an obligation to implement tobacco control measures and that these measures were linked section 27(1)(a) of the Constitution, stating:

> There can be no question that government has an obligation to protect its citizens from the ravages of tobacco use. Smoking is undoubtedly hazardous and has an adverse effect on health care. In terms of s 27(1) of the Constitution everyone has the right to have access to health care services which the State is obliged to provide and to carry the costs of, if necessary.[109]

The BAT case aligns with the communitarian approach to the enforcement of the right to healthcare adopted in Soobramoney and TAC; but extends this content to – when read with section 24, the right to a healthy environment – the prevention of illness and disease through measures that fall outside the healthcare context. The BAT decision provides an interpretation of the right to healthcare that can be used to buttres and strengthen public health interventions – even where the beneficiaries of these protections cannot be discretely identified.

This approach was reinforced and further developed during the COVID-19 pandemic. During the pandemic, the government was tasked with navigating the terrain of how best to respond to a novel virus with a limited array of public health interventions – most of which did not involve the provision of healthcare services and did not target specific individuals but the population as a whole. The subsequent legal challenges to this response resulted in jurisprudence which expanded the application of section 27(1)(a) beyond access to healthcare services to include disease prevention measures and broader efforts to protect and improve public health.

In Esau, for example, the Minister was tasked with defending a suite of measures aimed at preventing the spread of COVID-19. In this regard, the Minister argued that the COVID-19 regulations worked to promote the rights to life, freedom and security of person and, importantly, access to healthcare system – not of a particular person but of broader South African society.[110] The Supreme Court of Appeal accepted the argument that these measures served to protect societal interests, specifically the right to life stating,

> In a sense, there has been something akin to a trade-off: the rights to freedom of movement, to dignity and to pursue a livelihood were limited to prevent the spread of Covid-19 and

> that, in turn, protected the right to life of many thousands of people, who would have died had the disease had the opportunity to run unchecked through the country.[111]

The role of these measures, and the balancing act government was engaged in, was described by Plasket JA as a form of protecting and promoting the rights of the collective of South African society through slowing the spread of the virus and allowing healthcare facilities to be better prepared and equipped.[112]

The High Court gave similar recognition of the role of NPIs in protecting the right to life in which concerned the constitutionality of the ban on sales of tobacco protects. In British American Tobacco South Africa (Pty) Ltd and Others v Minister[113] and in Fair-Trade Independent Tobacco Association (FITA),[114] the Minister again invoked the right to life and the strain on the public health care system to justify the prohibition. In this regard, the Court said the following on the right to health and the duties it imposes during a pandemic:

> The Constitution imposes positive duties on the State to protect, promote and fulfil the rights in the Bill of Rights – including the right to life and the right to access to healthcare services. Thus, the State has a duty to take steps to prevent the spread of disease and to reduce the burden on the healthcare system, so as to ensure that those who need these services can have access to them. This duty is particularly acute in a pandemic.[115]

This reading of section 27(1)(a) which would encompass a measure such as a ban on tobacco sales to protect the capacity of the healthcare system was successful in FITA which the court expressly finding that the ban was in line with the state's duty under section 27(1)(a):

In One South Africa,[116] the Court went even further in expanding the content of section 27 beyond COVID-19 measures. The broad reading adopted by the court sees the realisation of the right to health – not purely in terms of ensuring access for patients but as part of broader social and development obligations. The court when so far as to read the growth of the economy as a means for the state to fulfil its obligations under section 27(1)(a), stating

> In this case, the constitutional issue implicates a range of fundamental rights, which pull in di□erent directions. The measures the state adopts to deal with the threat posed to the right to life must in turn safeguard and protect other constitutional rights which are also a□ected by the Covid-19 crisis. Section 7(2) expressly requires this of the state. These include, for example, the right to reasonable access to health care services for all the population, and not only for Covid-19 patients; the right to freedom of movement; the right to dignity which attaches to the ability to earn a living and feed one's family; the right to free choice of one's trade, profession and occupation; and the right to property. Moreover, the measures that the state adopts must also not hinder its ability to meet its constitutional obligations progressively to provide access to housing, social-welfare, health care and education. The health of the economy and fiscus are central to its ability to do so.[117]

This interpretation is likely heavily influenced by the context of the case as the applicants were arguing for a continuation of hard lockdown to prevent the spread of COVID-19 and save lives where the government was defending its e□orts to re-open the economy which would likely compromise public health to some degree. Consequently, the communitarian approach to interpreting the right to health doesn't always result in the

prioritisation of public health over individual interests but contemplates a balancing between competing interests of health and community well-being.

6. Discussion

These cases show the operation of a communitarian approach to the right to health in furtherance of public health measures across di□erent epidemics. The scope of the right to health and its development as a communitarian right in South Africa span three epidemics, HIV, non-communicable diseases and COVID-19. Within each of these, the public health interventions proposed and the Courts' consideration of the impact these measures will have on rights was not limited to those parties immediately before the Courts or most directly a□ected by the intervention.

Rather, by adopting a community-oriented approach to the interpretation and operation of the right to health, the Courts have been able to utilise the right to health to protect the interests of the broader community and public health objectives. This highlights the core element of reciprocity which underpins communitarianism, namely that in exercising an individual right, one must have regard to the rights of others as well as the broader interests of society. In these cases, that broader interest has e□ectively been public health considerations but, in operationalising this approach, the South African courts have opted to frame these considerations not just in terms of public good but also as part of the entitlement the broader community has to access healthcare services. Thus, the other tenet of communitarianism as observed in the African Charter is reflected in the jurisprudence of South Africa, the sense that rights are not held by and owed solely to individuals but may also be held collectively.

The operation of the right to health in the South African context has been developed beyond an individual entitlement of access to healthcare to now concern state obligations to fulfil and protect the right to access healthcare services held by South Africans outside the parties immediately litigating and without the need to specifically identify rights-holders. This has enabled the Courts to develop and apply what is e□ectively a right to public health, without the need for such a right to be formally codified in the Constitution. Rather, through the adoption of communitarian principles, the content of existing rights, such as the right to healthcare, may be expanded to include the interests of public health without the need for novel human rights instruments.

This approach has an additional benefit in that it avoids the distortion of priorities that so often has emanated from judicial intervention in the healthcare system. The communitarian framing has enabled the protection of the broad goals of public health through the recognition of communitarian entitlements under the right to health, even where the beneficiaries and rights-holders may not be easily ascertainable and discrete as would normally be the expectation in litigation. This means that, in making decisions, the judiciary must have regard to the impact the outcome may have on the rights of others – due to the interdependence of the individual and collective rights and avoids having the rights of those before a Court being prioritised over community well-being and common good.

Finally, the communitarian approach to the right to health has a clear advantage to the traditional framing of the right to health under international law in that it reconciles the apparent conflict between individual and collective entitlements by accommodating both and balancing them to reach an outcome that is best for the community.

7. Conclusion: the communitarian model as a way forward for the right to public health

There is an immense value in integrating public health into human rights frameworks. Particularly in epidemic response situations, a right to public health can provide a means to buttress and protect public health responses from opposition and challenges. However, this idea of a 'right to public health' has, until now, remained under-developed.

This paper has sought to use the communitarian approach, through the lens of South African jurisprudence, to propose a mechanism to recognise a right to public health within the existing human rights infrastructure of the right to health. This approach to a communitarian interpretation of the right to health, firmly buttressed by other civil and political rights, offers a pathway to develop the content of a traditionally individualistically framed right to health to include public health. This communitarian approach to the right to health can have utility and application in supporting and guiding action for future epidemic responses, particularly where the response involves interventions that are (i) outside the healthcare sector, (ii) benefit a collective and (iii) protect the rights of this collective.

While the enforcement of the right to health has long been plagued with complexities such as the phenomenon of the judicialisation of healthcare, the communitarian approach offers an antidote to these difficulties, enabling countries to leverage on their existing human rights architecture to promote broader public health objectives.

Notes

1. Benjamin Mason Meier and Larisa M. Mori, 'The Highest Attainable Standard: Advancing a Collective Human Right to Public Health', Columbia Human Rights Law Review 37 (2005): 146.
2. See note 1 above.
3. See Kristi Heather Kenyon, Lisa Forman, and Claire E. Brolan, 'Deepening the Relationship between Human Rights and the Social Determinants of Health', Health and Human Rights 20, no. 2 (December 2018): 1; Audrey R. Chapman, 'The Social Determinants of Health, Health Equity, and Human Rights', Health & Human Rights 12 (2010): 12. where they describe the relationship between social determinants of health and human rights as

   > The social determinants of health and human rights describe where and how we live and thrive. They express our actual and optimal conditions of housing and nutrition; our social, cultural, and spiritual connections; our access to education, health, and social services; and our ability to be fully involved in our societies through expression, mobility, association, work, and engagement with the formal political process.

4. Office of the High Commission, United Nations Human Rights 'Universal Declaration of Human Rights at 70: 30 Articles on 30 Articles – Article 25', https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=23970&LangID=E (accessed September 10, 2021).
5. Ryan Rollinson, 'Public Health and Human Rights in an Era of Epidemics', Advocates Forum 2015, 47–55.
6. See note 1 above at 122.
7. See note 1 above.
8. See note 1 above at 122.
9. Donald E. Low, 'Pandemic Planning: Non-pharmaceutical Interventions', Respirology 13 (2008): S44–48; World Health Organization Writing Group, 'Nonpharmaceutical

Interventions for Pandemic Influenza, National and Community Measures', Emerging Infectious Diseases 12, no. 1 (2006): 88; T. Alex Perkins and Guido España, 'Optimal Control of the COVID-19 Pandemic with Non-Pharmaceutical Interventions', Bulletin of Mathematical Biology 82, no. 9 (2020): 1–24.

10. Rebecca Kanter, Lana Vanderlee, and Stefanie Vandevijvere, 'Front-of-Package Nutrition Labelling Policy: Global Progress and Future Directions', Public Health Nutrition 21, no. 8 (2018): 1399–1408.
11. Leslie London, 'What is a Human-Rights Based Approach to Health and Does it Matter?', Health and Human Rights (2008): 65–80; Paul Hunt, 'Interpreting the International Right to Health in a Human Rights-Based Approach to Health', Health and Human Rights 18, no. 2 (2016): 109; Brian Citro et al., 'Developing a Human Rights-Based Approach to Tuberculosis', Health and Human Rights 18, no. 1 (2016): 1; Elvira Beracochea, Corey Weinstein, and Dabney P. Evans, eds., Rights-Based Approaches to Public Health (New York: Springer Pub. Co, 2011).
12. See note 1 above at 118–19.
13. Jonathan M. Mann et al., 'Health and Human Rights', Health and Human Rights 1, no. 1 (1994): 6–23.
14. Audrey Lebret, 'COVID-19 Pandemic and Derogation to Human Rights', Journal of Law and the Biosciences 7, no. 1 (2020): lsaa015.
15. Sharifah Sekalala et al., 'Health and Human Rights Are Inextricably Linked in the COVID-19 Response', BMJ Global Health 5, no. 9 (2020): e003359; Leonard Rubenstein and Matthew Decamp, 'Revisiting Restrictions of Rights After COVID-19', Health and Human Rights 22, no. 2 (2020): 321; Lebret, 'COVID-19 Pandemic and Derogation to Human Rights'.
16. Constitution of the Republic of South Africa, 1996.
17. N. Kirby, 'Access to Healthcare Services as a Human Right', Medicine & Law 29 (2010): 487; Charles Ngwena, Rebecca Cook, and Ebenezer Durojaye, 'The Right to Health in Post-Apartheid Era South Africa', Advancing the Human Right to Health (2013), 129–41.
18. Section 27(1)(a) of the Constitution.
19. Constitution of the World Health Organization adopted by the International Health Conference held in New York from 19 June to 22 July 1946, signed on 22 July 1946 (WHO Constitution).
20. Michael Marmot, 'Social Determinants of Health Inequalities' The Lancet 365 (2005): 1099, at 1102.
21. Lawrence O. Gostin, Global Health Law (2014) at 257.
22. International Covenant on Economic, Social and Cultural Rights, Adopted and opened for signature, ratification and accession by General Assembly resolution 2200A (XXI) of 16 December 1966, entry into force 3 January 1976.
23. UN. Committee on Economic, Social and Cultural Rights "General comment no. 14 (2000), The right to the highest attainable standard of health (article 12 of the International Covenant on Economic, Social and Cultural Rights)".
24. Article 25, sub-section 2 of the WHO Constitution.
25. General Comment 14 at para 4.
26. See note 23 above at para 9.
27. Declaration of Alma-Ata at para I (emphasis added).
28. See note 26 above at para III.
29. World Health Organisation, 'Ottawa Charter for Health Promotion: the 1st International Conference on Health Promotion, Ottawa, 1986', https://www.who.int/healthpromotion/conferences/previous/ottawa/en/ (accessed May 22, 2020) (emphasis added).
30. See note 29 above.
31. See note 29 above.
32. Convention on the Elimination of All Forms of Discrimination against Women adopted by the United Nations General Assembly on 18 December 1979, entered into force on 3 September 1981. (CEDAW).
33. Article 12 of CEDAW.

34. United Nations, 'Convention on the Rights of the Child, adopted by General Assembly resolution 44/25 of 20 November 1989', entered into force 2 September 1990 (CRC).
35. See for example, articles 10, 13, 14 of the CRC.
36. Article 24.1 of the CRC.
37. Article 24.2 of the CRC.
38. See Courtney Jung, Ran Hirschl, and Evan Rosevear, 'Economic and Social Rights in National Constitutions', The American Journal of Comparative Law 62, no. 4 (2014): 1043–93 Who found that over 70% of domestic legal systems recognised a right to health, whether in constitutions or jurisprudence, and a 40% of countries recognised a justiciable right to health.
39. See note 1 above at 117 and 136 where they state:

> Whereas traditional human rights scholarship views 'man' as 'a separate isolated individual who, as such and apart from any social context, is bearer of rights,' combating the health disparities of a globalized world will require renewed focus on the collective social factors that facilitate the spread of disease. Creating societal interventions to combat these societal determinants of health will require broad public health infrastructures that move well beyond the individual curative model of medicine.

40. Petronell Kruger and Safura Abdool Karim, 'A Human Rights-based Approach to Coercive Public Health Interventions: Lessons from the HIV and COVID-19 Pandemics', African Journal of AIDS Research 21, no. 2 (2022): 123–131.
41. Lauren Westra, 'Collective Human Rights: Public Health v Structural and Ecological Violence (The Example of Ecuador v. Colombia)', ILSA Journal of International and Comparative Law 16, no. 2 (2010): 557–572.
42. Michael A. Elliott, 'Human Rights and the Triumph of the Individual in World Culture', Cultural Sociology 1, no. 3 (November 1, 2007): 350, https://doi.org/10.1177/1749975507082052.
43. See note 21; note 13; and note 40 above.
44. Elizabeth Weeks Leonard, 'The Public's Right to Health: When Patient Rights Threaten the Commons', Washington University Law Review 86 (2008): 1335; Octavio Luiz Motta Ferraz, 'The Right to Health in the Courts of Brazil: Worsening Health Inequities?', Health and Human Rights (2009), 33–45; Luciana de Melo Nunes Lopes et al., '(Un) Equitable Distribution of Health Resources and the Judicialization of Healthcare: 10 Years of Experience in Brazil', International Journal for Equity in Health 18, no. 1 (2019): 1–8.
45. Everaldo Lamprea, 'The Judicialization of Health Care: A Global South Perspective', Annual Review of Law and Social Science 13, no. 1 (2017): 431–49, https://doi.org/10.1146/annurev-lawsocsci-110316-113303.
46. João Biehl and others, 'Judicialization 2.0: Understanding Right-to-Health Litigation in Real Time', Global Public Health 14 (2019): 190, https://doi.org/10.1080/17441692.2018.1474483 (accessed September 20, 2021); Mason-Meier and Mori, 'Right to Public Health'.
47. See note 46 above.
48. D. Bilchitz, 'South Africa: Right to Health and Access to HIV/AIDS Drug Treatment', International Journal of Constitutional. Law 1 (2003): 524; M. Heywood, 'South Africa's Treatment Action Campaign: Combining Law and Social Mobilization to Realize the Right to Health', Journal of Human Rights Practice 1 (2009): 14; E.J. Broster, 'Litigating the Right to Health Care in South Africa', in Litigating the Right to Health in Africa: Challenges and Prospects, ed. E. Durojaye (2016), 102.
49. Biehl et al., 'Judicialization 2.0'.
50. Everaldo Lamprea, 'The Judicialization of Health Care: A Global South Perspective', Annual Review of Law and Social Science 13, no. 1 (2017): 431–49, https://doi.org/10.1146/annurev-lawsocsci-110316-113303; Luciana Souza d'Ávila, Eli Iola Gurgel Andrade, and Fernando Mussa Abujamra Aith, 'Judicialization of Health in Brazil and Colombia: A Discussion in Light of the New Latin American Constitutionalism1', Saúde e Sociedade 29 (August 26, 2020), https://doi.org/10.1590/S0104-12902020190424.

51. This debate in not directly relevant to the arguments and discussion advanced in this section and thus, is only noted insofar as it presents a point of departure to understand the significance of a collectivist interpretation and enforcement of rights. However, should the reader wish to understand the impacts of judicialization of healthcare and the debates concerning its e□ect of equity, the issues are discussed comprehensively in Tatiana S. Andia and Everaldo Lamprea, 'Is the Judicialization of Health Care Bad for Equity? A Scoping Review', International Journal for Equity in Health 18, no. 1 (June 3, 2019): 61, https://doi.org/10.1186/s12939-019-0961-y and João Biehl, Mariana P. Socal, and Joseph J. Amon, 'The Judicialization of Health and the Quest for State Accountability: Evidence from 1,262 Lawsuits for Access to Medicines in Southern Brazil', Health and Human Rights Journal 18, no. 1 (04 2016), https://www.hhrjournal.org/2016/04/the-judicialization-of-health-and-the-quest-for-state-accountability-evidence-from-1262-lawsuits-for-access-to-medicines-in-southern-brazil/.
52. Lamprea, 'The Judicialization of Health Care.'
53. Ibid.
54. João Biehl, 'The Pharmaceuticalization and Judicialization of Health: On the Interface of Medical Capitalism and Magical Legalism in Brazil', Osiris 36, no. 1 (2021): 309–27; Lamprea, 'The Judicialization of Health Care', 432.
55. Mason Meier and Mori, 'The Highest Attainable Standard', 124.
56. Mason Meier and Mori, 'Right to Public Health', 101.
57. Ibid., 102.
58. Ibid., 118, where they state succinctly 'Globalization has taken responsibility for health out of the control of the individual, predetermining harm at the societal level'.
59. Mason Meier and Mori, 102, discuss this not in the context of interventions but instead in relation to policies, indicating the epidemic control needs to extend beyond healthcare policies to areas such as economic development, gender and politics. However, the same reasoning should apply – and has been applied – to the social determinants of health.
60. Mason Meier and Mori, 117.
61. Ibid., 117–18.
62. This point is further reinforced by the discussion below on the judicialisation of the right to health.
63. P.H. Coetzee, 'Particularity in Morality and its Relation to Community', in Philosophy from Africa: A Text with Readings, 2 ed., eds. P.H. Coetzee and A.P.J. Roux (2002), 276.
64. J.S. Mbiti, African Religions & Philosophy (1990) 141.
65. P.H. Coetzee, 'Particularity in Morality and its Relation to Community', in Philosophy from Africa: A Text with Readings, 2nd ed., eds. P.H. Coetzee and A.P.J. Roux (2002), 276. See, also, M.B. Ramose, 'The Ethics of Ubuntu', in Philosophy from Africa: A Text with Readings, 2nd ed., eds. P.H. Coetzee and A.P.J. Roux (2002), 326.
66. Lisa Forman, 'Justice and Justiciability: Advancing Solidarity and Justice through South Africans' Right to Health Jurisprudence Access to Health Care', Medicine and Law 27, no. 3 (2008): 680.
67. Muleki Munyuka and Mokgethi Mothlabi, 'Ubuntu and Its Socio-Moral Significance', in African Ethics: An Anthology of Comparative and Applied Ethics, ed. Munyaradzi Felix Murove (Scottsville: University Of KwaZulu-Natal Press, 2009), 65.
68. M.B. Ramose, African Philosophy Through Ubuntu (1999) 43.
69. J.Y. Mokgoro, 'Ubuntu and the Law in South Africa', PER/PELJ 1 (1998): 4.
70. South African Police Service v Solidarity obo Barnard 2014 (6) SA 123 (CC) para 174. See also Makwayane, paras 225, 241, 308; Ho□mann v South African Airways 2000 (1) SA 1 (CC).
71. Makwanyane, para 263; Port Elizabeth Municipality, para 37.
72. Makwanyane, para 250.
73. African (Banjul) Charter on Human and Peoples' Rights, adopted 27 June 1981, OAU Doc. CAB/LEG/67/3 rev. 5, 21 I.L.M. 58 (1982), entered into force 21 October 1986.
74. Article 16 of the African Charter.
75. Article 16.2 of the African Charter.

76. African Commission on Human and Peoples Rights, Communication 155/96, the Social and Economic Rights Action Centre & Centre for Economic and Social Rights v Nigeria, Fifteenth Annual Activity Report (SERAC).
77. Ibid., 9.
78. Ibid., 10.
79. Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa, adopted on 11 July 2003, entered into force 25 November 2005 (the Maputo Protocol).
80. Harmful practices are defined in the Protocol as 'all behaviour, attitudes and/or practices which negatively a□ect the fundamental rights of women and girls, such as their right to life, health, dignity, education and physical integrity'.
81. African Charter on the Rights and Welfare of the Child, adopted July 1990, entered into force on 29 November, 1999.
82. Article 14 of the African Children's Charter.
83. Anneth Amin, 'The Potential of African Philosophy in Interpreting Socio-Economic Rights in the African Charter on Human and Peoples' Rights', African Human Rights Yearbook (AHRY) 2021 (2021): 23–50.
84. Amin, 'African Philosophy'; Louis O. Oyaro, 'Rearticulating Ubuntu as a Viable Framework for the Realisation of Legal Capacity in Sub-Saharan African', African Disability Rights Yearbook 6 (2018): 82–98.
85. Benjamin Elias Winks, 'A Covenant of Compassion: African Humanism and the Rights of Solidarity in the African Charter on Human and Peoples' Rights', African Human Rights Law Journal 11, no. 2 (2011): 447–64.
86. Article 27 of the African Charter.
87. Winks, 'Covenant of Compassion'.
88. Drucilla Cornell and Karin Van Marle, 'Exploring Ubuntu: Tentative Reflections', African Human Rights Law Journal 5, no. 2 (2005): 195–220.
89. Ibid.
90. Oyaro, 'Rearticulating Ubuntu'.
91. Constitution of the Republic of South Act 200 of 1993.
92. T.W. Bennett, A.R. Munro, and P.J. Jacobs, Ubuntu: An African Jurisprudence (2018), 60.
93. See, for example, the comments by various Constitutional Court Justicies in the landmark case of S v Makwanyane [1995] ZACC 3, 1995 (3) SA 391 at paras 224, 226, and 263. See also, Dikoko v Mokhatla 2006 (6) SA 235 (CC) para 113, and Barkhuizen v Napier 2007 (5) SA 323 (CC) para 51.
94. Port Elizabeth Municipality v Various Occupiers 2005 (1) SA 217 (CC) para 37.
95. Bilchitz, 'South Africa'; Forman, 'Justice and Justiciability'.
96. Forman, 'Justice and Justiciability'.
97. Soobramoney v Minister of Health (Kwazulu-Natal) [1997] ZACC 17; 1998 (1) SA 765 (CC); 1997 (12) BCLR 1696.
98. Forman, 'Justice and Justiciability', 669.
99. This exceptionalism of South Africa in the trend of the Global South is investigated more comprehensively in Kaushik Sunder Rajan, 'Just Health?: Law, Constitutionalism and Post-colonial Dis-ease', Draft paper for Wish Seminar, WISER, 7 September 2020, https://wiser.wits.ac.za/system/files/seminar/Rajan2020.pdf (accessed June 30, 2021).
100. Soobramoney, para 28.
101. Ibid., para 31.
102. Ibid., para 52–4 which in relevant part reads:

> In a case such as the present which engages our compassion to the full, I feel it necessary to underline the fact that Chaskalson P's judgment, as I understand it, does not merely "toll the bell of lack of resources". In all the open and democratic societies based upon dignity, freedom and equality with which I am familiar, the rationing of access to life-prolonging resources is regarded as integral to, rather than

> incompatible with, a human rights approach to health care … .The inescapable fact is that if governments were unable to confer any benefit on any person unless it conferred an identical benefit on all, the only viable option would be to confer no benefit on anybody

103. Soobramoney supra note at para 54.
104. TAC, para 37.
105. Ibid., para 94.
106. British American Tobacco South Africa (Pty) Ltd v Minister of Health and Another, case number 60230/2009, High Court of South African, North Gauteng, Pretoria at para 35.
107. British American Tobacco South Africa (Pty) Ltd v Minister of Health [2012] 3 All SA 593 (SCA) at para 28.
108. Ibid at para 20 which states:

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

109. Ibid at para 26.
110. Esau, para 121 which reads:

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

111. Esau, para 132.
112. Ibid., para 130.
113. British American Tobacco South Africa (Pty) Ltd and Others v Minister of Co-operative Governance and Traditional A□airs and Others [2020] ZAWCHC 180 (BAT III).
114. Fair-Trade Independent Tobacco Association v President of the Republic of South Africa and Another 2021 (1) BCLR 68 (GP).
115. BAT III supra note 109 at para 89.
116. One South Africa Movement and Another v President of the Republic of South Africa and Others 2020 (5) SA 576 (GP).
117. One South Africa Movement supra note 113 at para 90.

Disclosure statement

No potential conflict of interest was reported by the author(s).

Funding

Funding for this research was provided by the Global Center for Legal Innovation on Food Environments at the O'Neill Institute, Georgetown University Law Centre.

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