

**THE RIGHT OF WOMEN WITH PSYCHO-SOCIAL DISABILITIES TO ACCESS MENTAL
HEALTH CARE IN SOUTH AFRICA: A CRITICAL ANALYSIS**

**A DISSERTATION SUBMITTED IN PARTIAL FULFILMENT OF THE REQUIREMENTS
FOR THE DEGREE LLM (HUMAN RIGHTS AND DEMOCRATISATION IN AFRICA)**

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Plagiarism declaration

I, BENEDICTA ARMAH, hereby declare that this dissertation is my own work, that it has not been submitted before for any degree or examination in any other university, and that all the sources I have used or quoted have been indicated and acknowledged as complete references.

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Dedication

To Mum and Dad for always believing in me.

Acknowledgment

To God be all the glory for how far he has brought me and for giving me the strength to go on.

I am grateful to my supervisor Dr Combrinck, for her patience and relentless effort to guide me through this research. Her constructive comments and insightful remarks helped me to shape this research into its present form.

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Key Words

- Right to mental health
- Women
- Psycho-social disability
- UN Convention on the Rights of Persons with Disabilities
- Mental health care
- Mental Health Care Act 17 of 2002
- South African Constitution Act 108 of 1996
- Barriers
- Accessibility

Abbreviations

CEDAW	- Convention on the Elimination of all Forms of Discrimination against Women
ESCR	- Committee on Economic, Social and Cultural Rights
CRPD	- Convention on the Rights of Persons with Disabilities
DWCP	- Department of Women, Children and People with Disabilities
ICCPR	- International Covenant on Civil and Political Rights
ICESCR	- International Covenant on Economic, Social and Cultural Rights
MHCA	- Mental Health Care Act
MHRBs	- Mental Health Review Boards
NGOs	- Non-governmental Organisations
UN	- United Nations
WHO	- World Health Organization

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Chapter one: Introduction

1.1 Background

Health is a fundamental human right which is necessary for the enjoyment of other rights.¹ Therefore international law guarantees the right to health care for women, specifically mental health care. These include the Universal Declaration on Human Rights (Universal Declaration); International Covenant on Economic, Social and Cultural Rights (ICESCR); Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and the Convention on the Rights of Persons with Disabilities (CRPD). The Universal Declaration and the ICESCR for example, recognise that the right to the highest attainable standard of physical and mental health includes the right to health care.²

The Convention on Persons with Disabilities (CRPD) guarantees the right of persons with disabilities to the highest attainable standard of health and sets out the state's duty to ensure access to health services which includes 'early identification and intervention as appropriate, and services designed to minimize and prevent further disabilities'.³ The provision of health care services with regards to persons with disabilities must be 'gender-sensitive including health-related rehabilitation'.⁴ This is due to the multiple discrimination suffered by women and girls with disabilities.⁵ In addition the rights of persons with disabilities 'to decide freely and responsibly on the number and spacing of their children and to have access to age-appropriate information, reproductive and family planning education is recognised by the CRPD'.⁶ In the area of sexual and reproductive health as well as population-based health programmes, persons with disabilities must be 'provided with the same range, quality and standard of free or affordable health care programmes as provided to other persons'.⁷ States further have the duty to identify and eliminate all obstacles or barriers to accessibility as it applies to the physical environment, transportation, information as well as services open or provided to the public both in urban and in rural areas including medical facilities and emergency services.⁸

The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) directs States Parties to 'take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure on equal basis with men, access

¹ United Nations Committee on Economic, Social and Cultural Rights General Comment No 14 (11 August 2000) E/C.12/2000/4, para 1.

² Universal Declaration of Human Rights (10 December 1948) G.A. res. 217A(III) article 25; International Covenant on Economic, Social and Cultural Rights (16 December 1966) G.A. res. 2200A(XXI) article 12; African Charter on Human and Peoples' Rights (1981/1986) Compendium of key human rights documents 2010 article 16; UN Committee on Economic, Social and Cultural Rights General Comment No 14(n 1 above) para 4.

³ UN Convention on the Rights of Persons with Disabilities (13 December 2006) A/RES/61/106, Annex 1, article 25, available at <http://www.unhcr.org/refworld/docid/480cd212.html> (accessed 29 August 2012).

⁴ Art 25.

⁵ Art 6.

⁶ Art 23(1)(b).

⁷ Art 25(a).

⁸ Art 9(1)(a).

to health care services, including those related to family planning'.⁹ States are also to ensure access to services related to pregnancy, confinement and the post-natal period, granting free services where necessary.¹⁰ CEDAW notes the peculiar problems faced by women in the rural areas and requests States Parties to take that into account and ensure that these women have access to adequate health care facilities, including information, counselling and services in family planning.¹¹

According to the WHO 'about 151 million people suffer from depression; 26 million people from schizophrenia; 125 million people are affected by alcohol use disorders; 40 million people suffer from epilepsy and 24 million from Alzheimer as well as other dementias'.¹² In spite of the 'widespread prevalence of mental health conditions, a large proportion of affected people do not receive treatment and care'.¹³

In many low-income and middle-income countries people do not have access to basic mental health care.¹⁴ In a study supported by the WHO, it was discovered that in developing countries, about seventy-six percent to eighty-five percent of persons with serious mental disorders had not received treatment in twelve months prior to the study.¹⁵ One major reason for this is the lack of adequate professional mental health personnel.¹⁶ For instance, in Africa there are 0.04 psychiatrists, 0.20 psychiatric nurses and 0.5 psychologists per 100 000 population.¹⁷ Moreover, psychosocial care and rehabilitation services and essential medicines are often unavailable, inaccessible or unaffordable, posing a challenge to treatment and recovery.¹⁸ The problems associated with affordability and access to mental health services in low-income and middle-income countries have been attributed to the scarcity of funding and services provided by the government.¹⁹

Being a major cause of disability and distress, mental health problems affects more women than men especially in Africa.²⁰ This is due to the 'common life stressors and events that are disproportionately experienced by women' which includes, childbearing, discrimination, sexual violence and the psychological costs of childcare²¹ as well as HIV.²²

⁹ The Convention on the Elimination of All Forms of Discrimination against Women (3 September 1981) 1249 UNTS article 12(1), available at <http://www2.ohchr.org/english/law/cedaw.htm> (accessed 29 October 2012).

¹⁰ Art 12(2).

¹¹ Art 14(2)(b).

¹² M Funk et al 'Mental health and development: treating people with mental health conditions as a vulnerable group' (2012) 2.

¹³ Funk et al (n 12 above) 15.

¹⁴ N Drew et al 'Human rights violations of people with mental and psychosocial disabilities: an unresolved global crisis' (2011) 378 *The Lancet* 1664-1675.

¹⁵ R Lazarus & M Freeman 'Primary-level mental health care for common mental disorders for resource-poor settings: Models & practice - a literature review. Sexual violence research initiative' (2009) 4.

¹⁶ Lazarus & Freeman (n 15 above) 4.

¹⁷ As above.

¹⁸ N Drew et al (n 14 above) 1670.

¹⁹ E Faydi et al 'An assessment of mental health policy in Ghana, South Africa, Uganda and Zambia' (2011) 9 *Health Research Policy and Systems* 17; S Saxena et al 'Resources for mental health: scarcity, inequity and inefficiency' (2007) 370 *The Lancet* 878-89.

²⁰ L Doyal & M Hoffman 'The growing burden of chronic diseases among South African women' (2009) 27 *Continuing Medical Education* 458.

²¹ A Moultrie & S Kleintjes 'Women's mental health in South Africa' (2006) 352.

Often the stigma associated with mental health conditions is due to the misconceptions about its causes compounds the problem.²³ For example in Africa, mental health conditions in women are believed to be caused by witchcraft.²⁴ Moreover mental health problems are of a particular burden among poorer women.²⁵ Other social factors such as domestic isolation and powerlessness are associated with higher prevalence of psychiatric illness in women.²⁶ The low social status of women have been described as the root cause of many emotional and health problems.²⁷ Though women play the main role of caregivers in society, they are not accorded the rights and status commensurate with this responsibility.²⁸ The long hours committed to work for low wages coupled with the demands of household chores and parenting, causes 'stress, tiredness and depression'.²⁹ Further women who have traumatic deliveries during childbirth may experience postnatal depression.³⁰ As a result of violence in the form of rape, battering and sexual harassment, women suffer emotional trauma.³¹ These peculiar life experiences of women based on their biological make up and societal roles demands that women's mental health needs be given special focus.³²

In South Africa, 'neuropsychiatric disorders' form the third cause of the national disease burden.³³ Despite this fact, mental health services 'are grossly under-resourced' and many barriers to health care for persons with mental disabilities exist.³⁴ These barriers include 'lack of accessibility, acceptability and availability of services, stigma, lack of awareness, perception that treatment may not effective, cultural beliefs, and language problems'.³⁵ Women with psycho-social disabilities generally face specific hurdles when it comes to accessing mental health care.³⁶ These hurdles stem from a host of factors ranging from biological or socio-economic factors to discrimination.³⁷ The burden of responsibility associated with being wives, mothers and care givers places time constraints on women;³⁸ such that most women are not willing to spend much of their time into seeking treatment.³⁹ In

²² G Davies et al 'Mental health challenges in HIV positive women, adolescents and children'(2002)11 *The Source*1.

²³ M Funk et al (n 12 above) 8.

²⁴ A Ofori-Atta et al 'Common understandings of women's mental illness in Ghana: results from a qualitative study' (2010) 22 *International Review of Psychiatry* 592.

²⁵ Doyal & Hoffman (n 20 above) 458.

²⁶ Moultrie & Kleintjes (n 21 above) 352.

²⁷ L Rispel & M Goosen 'Women and the health care system' in M Goosen et al (eds) *The South African women's health book* (1996) 481.

²⁸ Rispel & Goosen (n 27 above) 481.

²⁹ As above.

³⁰ As above.

³¹ As above.

³² Rispel & Goosen (n 27 above) 483.

³³ S Seedat et al 'Mental health service use among South Africans for mood, anxiety and substance use disorders' (2009) 99 *South African Medical Journal* 346.

³⁴ As above.

³⁵ As above.

³⁶ UN Office of the High Commissioner for Human Rights, *Fact Sheet No. 31: The Right to Health* (2008) No. 31, available at: <http://www.unhcr.org/refworld/docid/48625a742.html> accessed (18 May 2012); S Saxena et al (n 33 above) 883.

³⁷ *Fact Sheet No 31: The Right to Health* (n 14 above) 11.

³⁸ MK Gomel 'Nations for mental health: a focus on women' (1997)1.

³⁹ Rispel & Goosen (n 26 above) 480.

South Africa where women constitute ‘the poorest, lowest paid workers’,⁴⁰ mental health care services offered on an in-patient basis in hospitals or mental institutions is unaffordable to its high cost.⁴¹ Women who suffer discrimination on account of their mental health conditions may avoid care and treatment.⁴² There is therefore a need for mental health workers to be ‘non-sexist, non-racist and culturally sensitive in order to meet the mental health needs of women’.⁴³

1.2 Problem Statement

The right to health, which includes the right to access health care, is guaranteed in international law, with specific reference to the position of women and particularly, women with disabilities. In spite of the fact that international instruments also set out state duties in respect of these rights, the reality is that the majority of persons with mental disabilities do not receive adequate health care; this is much worse for women, especially those in developing or low-income countries.

1.3 Research questions

- Whether the existing legal framework guarantees the right to access to mental health care for women with psycho-social disabilities in South Africa?
- To what extent does the legal framework guarantee the right to access mental health care by women with psycho-social disabilities in light of current international human rights law?

1.4 Focus and objectives of the study

- To understand the legal framework regulating or providing mental health care in South Africa.
- To examine the extent to which the legal framework guarantees of the right to access mental health care by women with psycho-social disabilities.
- To explore possible ways of increasing access to mental health care for women with psycho-social disabilities in South Africa.

1.5 Significance of the study

This research aims to establish how the laws guarantee the right to access mental health care by women with psycho-social disabilities. Further this research would establish how economic, geographical and socio-cultural factors affect the right to access mental health care. Its findings are to contribute to the literature existing on disabilities generally and more specifically on women with psycho-social disabilities which suffers a dearth in research.

⁴⁰ Moultrie & Kleintjes (n 22 above) 356.

⁴¹ Rispel & Goosen (n 26 above) 482.

⁴² G Thornicroft et al ‘Discrimination in health care against people with mental illness’ (2007)19 *International Review of Psychiatry* 116.

⁴³ Rispel & Goosen (n 26 above) 483.

1.6 Research methodology

The study consisted of a desk-top literature study. As primary sources of data the researcher analysed a number of documents such as international and African regional human rights instruments; sub-regional instruments; various pieces of legislation and policy documents. As secondary sources text books, articles and internet sources were consulted.

The researcher chose South Africa because it is a middle-income country where there is a lack of access to mental health care services despite the country's expenditure on health as compared to other middle-income countries.⁴⁴ The researcher also considered the proximity to reliable data.

1.7 Limitations

This study is limited in so far as it examines the international human rights system; African Regional human rights system and the Southern African Development Community's guarantee of the right of women with psycho-social disabilities to access mental health care. It does not examine other regional human rights systems such as the European human rights system. This approach was chosen in order to provide a good background to the development of human rights law with regards to persons with disabilities generally and to persons with mental disabilities specifically.

In relation to the difficulties experienced with regard to this research, the researcher faced difficulty in accessing materials on the topic. This was due in part to the fact that the area is under-researched. Therefore the research is only focused on South Africa to ensure a detailed study of the state's laws, institutions and policies in fulfilling its obligations under human rights law in relation to the topic.

Another limitation encountered resulted from the time available for the research. Due to the short time frame, the researcher was unable to secure research ethics approval to conduct interviews which would have formed part of the primary source of data for the research.

1.8 Operational definition of terms

Mental health according to the World Health Organization (WHO) is 'a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community';⁴⁵ it 'is not just the absence of mental disorder'.⁴⁶

Mental illness is 'a diagnosable illness that significantly interferes with an individual's cognitive, emotional and/ or social ability'.⁴⁷ However not all mental illnesses cause impairments.⁴⁸

⁴⁴ South Africa spends 8.5% of its GDP on health which is far above the 5% recommended by the WHO, see Department of Health 'National health insurance in South Africa: policy paper (2011) 9.

⁴⁵ WHO (2007), available at <http://www.who.int/features/qa/62/en/index.html> (accessed 29 October 2012).

⁴⁶ WHO (n 45 above).

⁴⁷ National Mental Health Consumer & Carer Forum 'Unravelling psychosocial disability' (2011) 7.

⁴⁸ As above.

Mental disabilities include ‘disabilities arising from major mental illness and psychiatric disorders, such as schizophrenia; more minor mental ill health and disorders, often called psycho-social problems, for example mild anxiety disorders; and intellectual disabilities’.⁴⁹

Psycho-social means ‘involving both psychological and social aspects’ or ‘relating social conditions to mental health’.⁵⁰ Thus psycho-social disability is a term used to describe disabilities that occur as a result of mental health conditions.⁵¹ The term ‘psychosocial’ stems from the social model of disability which postulates that disability is the interaction between the impairment and the social or barriers faced by a person with disability such as discrimination and stigma.⁵² It is therefore the ‘preferred term of some users of mental health services’⁵³ and has been accepted by the disability rights movement at the UN level. The CRPD on the other hand, does not use the term ‘psycho-social disabilities’ but rather employs the term ‘mental disabilities’.⁵⁴ Thus this research uses both terms simultaneously. Where the term ‘mental disability’ is used in this research, it is meant to apply to persons with psycho-social disabilities as well.

Mental health care refers to mental health services such as psychosocial care, rehabilitation and essential medicines, needed by persons with mental disabilities ‘specifically because of their disabilities as well as services designed to minimize and prevent further disabilities’.⁵⁵ With regards to women, mental health care should include services related to sexual and reproductive health such as pregnancy, childbirth as well as counselling services.

1.9 Models of disability

The medical model of disability considers disability as a state similar to illness which limits the individual’s ability to function effectively in society.⁵⁶ It therefore proposes ‘therapy and technical or personal support’ as solutions to disability.⁵⁷ The medical model has also been criticised by feminist disabled persons for its inability to address the gender dimensions of disability as it focuses on the disability and not the person.⁵⁸ Consequently, the ‘male-oriented’ nature of ‘rehabilitation aids and social services’, does not cater for the needs of women.⁵⁹

⁴⁹ P Hunt & J Mesquita ‘Mental disabilities and the right to the highest attainable standard of health’ (2006) 28 *Human Rights Quarterly* 336.

⁵⁰ National Mental Health Consumer & Carer Forum (n 47 above) 6.

⁵¹ National Mental Health Consumer & Carer Forum (n 47 above) 7.

⁵² C Barnes ‘The social model of disability: A sociological phenomenon ignored by Sociologists?’ in T Shakespeare(ed) *Disability reader: Social science perspectives* (1998) 66.

⁵³ CBM ‘Community mental health policy’ (2008) 2, available at

http://www.cbm.org/article/downloads/54003/CBR_Policy_Mental_Health_Services_Context_CBR_April_2002_0_pdf (accessed 22 October 2012).

⁵⁴ Art 1.

⁵⁵ Art 25(b).

⁵⁶ T Degener ‘Disabled women and international human rights’ (2001) 3 *Women and International Human Rights Law* 267

⁵⁷ Degner (n 56 above) 275.

⁵⁸ Degner (n 56 above) 276.

⁵⁹ As above.

In the 1980s, the social model of disability emerged. As opposed to the medical model, the social model postulated that disability was the outcome of 'social organisation';⁶⁰ that it is the interaction between the impairment and the environmental or social barriers faced by disabled people.⁶¹ Around the same time, there was a remarkable shift to the rights model.⁶² The human rights model focuses on the 'inherent dignity of the human being and subsequently, but only if necessary, on the person's medical characteristics'.⁶³ The individual plays an important role in decision-making which affects him or her.⁶⁴ This model unlike the medical model, blames the problems faced by persons with disabilities from the lack of state and civil society response to the societal barriers faced by persons with disabilities.⁶⁵

1.10 Hypothesis

The accessibility of affordable and quality mental health care by women with psycho-social disabilities depends on the extent to which the legal framework and policies of the state are tailored to guarantee access. Therefore the underlying assumption of this research is that where there is no effective implementation of laws and policies the right to access health care cannot be realised. The current international human rights framework on persons with disabilities led by the CRPD provides for the adequate guarantee of the right to access health care by persons with disabilities generally and women with psycho-social disabilities specifically in light of the biological, cultural and socio-economic barriers faced by women. The need to remove these barriers requires commitment from State Parties to the CRPD in implementing their obligations.

1.11 Literature review

In South Africa, the right to access health care services is entrenched in the Bill of Rights of the 1996 Constitution.⁶⁶ The state has ratified the United Nations Convention on the Rights of Persons with Disabilities with its optional protocol,⁶⁷ the UN Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)⁶⁸ and the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa.⁶⁹ Moreover a Mental Health Care Act 2002 was enacted to provide care, treatment and rehabilitation of persons with mental disabilities and to improve mental health services through primary health

⁶⁰ B Hughes & K Paterson 'The social model of disability and the disappearing body: towards a sociology of impairment, disability & society (1997)12 *Disability and Society* 325-340.

⁶¹ C Barnes 'The social model of disability: A sociological phenomenon ignored by Sociologists?' in T Shakespeare(ed) *Disability reader: Social science perspectives* (1998) 66.

⁶² Quinn & Degener 'Human rights and Disability: The current use and future potential of the United Nations human rights instruments in the context of disability' (2004) 30.

⁶³ Quinn & Degener (n 62 above) 14.

⁶⁴ As above.

⁶⁵ As above.

⁶⁶ Sec 27.

⁶⁷ JK Burns 'The mental health gap in South Africa:A human rights issue'(2011) 6 *The Equal Rights Review* 99-113.

⁶⁸ Status of ratification, available at http://www.bayefsky.com/pdf/cedaw_ratif_table.pdf (accessed 30 August 2012).

⁶⁹ Ratification Table:Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa,available at <http://www.achpr.org/instruments/women-protocol/ratification/> (accessed 30 August 2012).

care.⁷⁰ Though South Africa has progressive mental health legislation, various barriers to the financing and development of health services exist which has affected the accessibility of mental health care services.⁷¹ In addition factors such as poverty, geographical barriers, gender and social exclusion has impacted negatively on the accessibility of mental health care for many persons with mental disabilities.⁷²

In last five years, only two percent of all health publications in the country was on mental health.⁷³ The areas of research included, 'epidemiological studies in community samples; services research; psychosocial interventions and policy'.⁷⁴ Research areas such as accessibility to and equity of care have been relatively neglected in comparison to published research in the field of HIV and AIDS.⁷⁵ A focus on mental health care by researchers would impact policy directives and practice towards improving accessibility to mental health care.

While research has been done on women's mental health in South Africa,⁷⁶ hardly any of these studies have focused on the right implication to access to mental health care for women with psycho-social disabilities. Moreover at the time of writing, the researcher to the best of her knowledge had not come across research on the right of women with psychosocial disabilities to access mental health care in South Africa. Thus, this research is relevant.

1.12 Outline of Chapters

This dissertation is divided into the following chapters;

Chapter two discusses the international legal framework guaranteeing the right to access health care by persons with disabilities in general and especially women with psychosocial disabilities. Secondly, it examines the African regional context and jurisprudence on the topic. It also takes a look at treaties from the Southern African Development Community which guarantee the right of women with psycho-social disabilities to mental health care

Chapter three explores the laws and policies guaranteeing the right to access health care by women with psycho-social disabilities in South Africa.

Chapter four examines the extent to which the legal and policy framework in South Africa guarantee the right of women with psycho-social disabilities to access mental health care. It assesses whether it meets the international standard set by the Convention on the Rights of persons with disabilities.

Chapter five contains the conclusion and recommendations.

⁷⁰ JV Rensburg 'A framework for current public mental health care practice in South Africa' (2007)10 *African Journal of Psychiatry* 205-209.

⁷¹ Burns (n 67 above) 8.

⁷² As above 12.

⁷³ World Health Organization 'WHO-AIMS Report on mental health system in South Africa' (2007) 15.

⁷⁴ As above.

⁷⁵ O Jack-Ide et al 'A comparative study of mental health services in two African countries: South Africa and Nigeria' (2012) 4 *International Journal of Nursing and Midwifery* 51.

⁷⁶ Moultrie & Kleintjes (n 22 above) 352; Doyle & Hoffman (n 21 above) 456.

Chapter two: The international and regional legal framework

2.1 Introduction

This chapter examines how the international, African regional and sub-regional human rights systems guarantee the rights of persons with disabilities with specific reference to women with psycho-social disabilities. It will give a brief background on the development of the rights of persons with mental disabilities at the international level and a detailed discussion on how the United Nations Convention on Persons with Disabilities guarantees the right to mental health care of women with psycho-social disabilities. The African Charter and the African Women's Protocol's guarantees of the rights to mental health care is examined as well as the Protocols of the South African Development Community on Gender and Development; and on Health.

2.2 Overview of the international human rights instruments guaranteeing the rights of persons with disabilities

The foundation for the protection of the rights of persons with disabilities is the United Nations Charter (UN Charter), the Universal Declaration of Human Rights (Universal Declaration), the International Covenant on Civil and Political Rights (ICCPR), the International Covenant on Economic, Social and Cultural Rights (ICESCR), and other related human rights documents.⁷⁷ The UN Charter encourages member states to assist in the realisation of human rights without distinction to race, sex, language or religion.⁷⁸ Adopted on the 10th December 1948, the Universal Declaration was intended to embrace the different economic and political ideologies in existence at the time.⁷⁹ Although not legally binding, it had moral and political force.⁸⁰ Its contents focused more on civil and political rights than economic, social and cultural rights.⁸¹ In spite of this the Universal Declaration played a major role by providing direction for the international protection of human rights and more specifically the rights of persons with disabilities.⁸² For instance its provisions on social security, work and education are applicable to persons with disabilities.⁸³ More specifically, Article 25 of the Universal Declaration recognises 'the right of everyone to a standard of living adequate for their health and the right to security in the event of disability'.⁸⁴ In recent times some of the provisions of the Universal Declaration have been understood by some to

⁷⁷ Background Paper prepared by the Division for Social Policy and Development of the United Nations Secretariat for the "Informal Consultative Meetings on International Norms and Standards for Persons with Disabilities." (9 February 2001), available at <http://www.un.org/esa/socdev/enable/rights/humanrights.htm> (accessed 19 August 2012).

⁷⁸ United Nations Charter (24 October 1945) 1 UNTS XVI, article 13(1)(b), available at <http://www.unhcr.org/refworld/docid/3ae6b3930.html> (accessed 19 August 2012).

⁷⁹ OM Arnardottir & G Quinn *The UN Convention on the Rights of Persons with Disabilities: European and Scandinavian perspectives* (2009) 381.

⁸⁰ Arnardottir & Quinn (n 79 above) 381.

⁸¹ H Steiner et al *International human rights in context: Law, politics and morals* (2007) 136.

⁸² Arnardottir & Quinn (n 79 above) 381.

⁸³ LO Gostin & L Gable 'The human rights of persons with mental disabilities: A global perspective on the application of human rights principles to mental health' (2004) *63 Maryland Law Review* 20.

⁸⁴ Universal Declaration of Human Rights (10 December 1948) 217 A(III), available at <http://www.unhcr.org/refworld/docid/3ae6b312c.html> (accessed 19 August 2012).

have gained the status of customary international law and thus binding.⁸⁵ Though the Universal Declaration established a common standard for assessing human rights conditions, it only refers to the rights generally and thus it is limited in its direct application to persons with disabilities.⁸⁶

2.2.1 Adoption of the ICCPR and ICESCR

The move to transform the Universal Declaration into legally binding documents saw the enactment of two instruments; the ICCPR and the ICESCR adopted in 1966.⁸⁷ Both treaties entered into force in 1976.⁸⁸ The category of rights enshrined in the ICCPR is of importance to persons living with disabilities.⁸⁹ This is first of all evidenced by the fact that though the non-discrimination clauses under articles 2 and 26 do not make specific reference to disability; 'other status' can be read to cover disability.⁹⁰ Other provisions of the ICCPR which guarantee the rights of persons with disabilities include those protecting liberty, privacy and prohibit cruel, inhuman and degrading treatment.⁹¹

The ICESCR does not refer explicitly to persons with disabilities.⁹² On this point the United Nations Committee on Economic, Social and Cultural Rights (ESCR Committee) has noted in General Comment number 5 that 'the absence of an explicit, disability-related provision in the ICESCR can be attributed to a lack of awareness of the importance of addressing the issue of disability explicitly, rather than only by implication'.⁹³ The ESCR Committee adopted General Comment number 5 in order 'to monitor the compliance of States parties to the ICESCR with their obligation to ensure the full enjoyment of the relevant rights by persons with disabilities'.⁹⁴ State party obligation to progressively realise the rights under the ICESCR to the maximum of their available resources; 'requires Governments to abstain from actions that might have a negative impact on the rights'.⁹⁵

In the case of persons with disabilities this obligation also 'requires a positive action by the state to reduce structural disadvantages to give appropriate preferential treatment to people with disabilities in order to achieve the objectives of full participation and equality within society for all persons'.⁹⁶ The ESCR Committee's recognition of structural barriers in the enjoyment of the rights of persons with disabilities accords with the social model of

⁸⁵ Steiner et al (n 81 above) 137.

⁸⁶ Gostin & Gable (n 83 above) 16.

⁸⁷ Arnardottir & Quinn (n 79 above) 382.

⁸⁸ Gostin & Gable (n 83 above) 16.

⁸⁹ G Quinn & T Degner 'Human rights and Disability: The current use and future potential of United Nations human rights instruments in the context of disability' (2002) 64.

⁹⁰ As above.

⁹¹ Gostin & Gable (n 83 above) 34.

⁹² UN Committee on Economic, Social and Cultural Rights (9 December 1994) E/1995/22, General Comment 5 para 5, available at <http://www.unhcr.org/refworld/docid/4538838f0.html> (accessed 19 August).

⁹³ General Comment 5 para 6.

⁹⁴ General Comment 5 para 2.

⁹⁵ General Comment 5 para 9.

⁹⁶ General Comment 5 para 9.

disability which attributes disability to societal barriers that inhibit the enjoyment of the rights of persons with disabilities.⁹⁷

When it comes to women with disabilities, the ESCR Committee notes the double discrimination they face because they are sometimes treated as 'genderless human beings' and therefore urges states to address the situation of women with disabilities by giving preference to the implementation of economic, social and cultural rights-related programmes.⁹⁸ The right of women with disabilities to protection and support in relation to motherhood and pregnancy, according to the ESCR Committee means that, abortions and sterilizations cannot be performed unless prior informed consent from the woman has been sought.⁹⁹ The ESCR Committee elaborated on the right to physical and mental health as implying the 'right to have access to, and to benefit from medical and social services which enable persons with disabilities to become independent, prevent further disabilities and support their social integration.'¹⁰⁰

2.2.2 The right to health under the ICESCR

The ICESCR recognises the 'right of everyone to the highest attainable standard of physical and mental health'.¹⁰¹ Towards the realisation of this right, Article 12(2)(d) of the ICESCR directs States parties to take steps necessary for the creation of conditions which would assure to all medical service and medical attention in the event of sickness.¹⁰² In its General Comment number 14, the ESCR Committee elaborated on article 12(2)(d) as including the provision of appropriate mental health treatment and care.¹⁰³ The ESCR Committee stated that Articles 2(2) & 3 of the ICESCR prohibits discrimination in access to health care based on the grounds provided in the Covenant as well as mental disability¹⁰⁴ and that equality of access to health care has to be emphasized.¹⁰⁵ Access to health care has three dimensions; physical accessibility, economic accessibility and information accessibility.¹⁰⁶ Physical accessibility implies 'that health facilities must be within safe physical reach including rural areas for the whole population, especially vulnerable groups such as women'.¹⁰⁷ The 'health facilities, goods and services in question must be affordable for all based on the principle of equity; whether privately or publicly funded'.¹⁰⁸ This underlies the element of economic

⁹⁷ C Barnes 'The social model of disability: A sociological phenomenon ignored by Sociologists?' in T Shakespeare(ed) Disability reader: Social science perspectives (1998) 66.

⁹⁸ General Comment 5 para 19.

⁹⁹ General Comment 5 para 31.

¹⁰⁰ General Comment 5 para 34.

¹⁰¹ International Covenant on Economic, Social and Cultural Rights (16 December 1966) United Nations, Treaty Series, vol 993 p 3, article 12, available at <http://www.unhcr.org/refworld/docid/3ae6b36c.0html> (accessed 19 August 2012).

¹⁰² Art 12(2)(d).

¹⁰³ UN Committee on Economic, Social and Cultural Rights (11 August 2000) E/C.12/2000/4, General comment 14 para 17, available at <http://www.unhcr.org/refworld/docid/4538838d0.html> (accessed 19 August 2012).

¹⁰⁴ General Comment 14 para 18.

¹⁰⁵ General Comment 14 para 19.

¹⁰⁶ General Comment 14 para 12(b).

¹⁰⁷ General Comment 14 para 12(b).

¹⁰⁸ General Comment 14 para 12(b).

accessibility.¹⁰⁹ Information accessibility means that the individual has the ‘right to seek, receive and impart information concerning health issues.’¹¹⁰ It then follows that any provision of mental health care services and goods must be within the physical reach of women with psycho-social disabilities; it must be affordable and women with psycho-social disabilities must be able to access any information regarding such mental health care services.

2.2.3 Specialised treaties

Specialised treaties were adopted such as the International Convention on the Elimination of All Forms of Racial Discrimination (ICERD) 1965¹¹¹ and the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) 1979.¹¹² The ICERD recognises ‘the right to public health, medical care, social security and social services’ in the context of race-based discrimination.¹¹³ CEDAW will be discussed below.

CEDAW

The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) directs states parties to take ‘appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on the basis of equality of men and women, access to health care services’.¹¹⁴ The CEDAW Committee has noted in its General Recommendation number 24 that ‘women with disabilities of all ages, often have difficulty with physical access to health services’.¹¹⁵ The CEDAW Committee also noted that women with mental disabilities are particularly vulnerable since they are often the victims of gender discrimination, violence and other forms of social deprivation.¹¹⁶ State parties are therefore to take appropriate measures to ensure ‘access to health services which are sensitive to the needs of women with disabilities and are respectful of their human rights and dignity’.¹¹⁷ These include services related to ‘family planning; pregnancy, confinement and the post-natal period as well as adequate nutrition during pregnancy and lactation’.¹¹⁸ CEDAW guarantees a woman’s ‘right to decide freely on the number and spacing of her children and to have access to the information, education and means to enable her exercise these rights’.¹¹⁹ States are to consider the peculiar problems faced by women in rural areas and ensure that they have access to adequate health care facilities including information,

¹⁰⁹ General Comment 14 para 12(b).

¹¹⁰ General Comment 14 para 12(b).

¹¹¹ International Convention on the Elimination of All Forms of Racial Discrimination (21 December 1965) United Nations, Treaty Series, vol. 660, p.195, available at <http://www.unhcr.org/refworld/docid/3ae6b3940.html> (accessed 19 August 2012).

¹¹² Convention on the Elimination of All Forms of Discrimination Against Women, 18 December 1979, United Nations, Treaty Series, vol. 1249, p.13, available at <http://www.unhcr.org/refworld/docid/3ae6b3970.html> (accessed 19 August 2012).

¹¹³ Art 5(e)(iv). The ICERD will not be discussed in detail due to the focus of this paper.

¹¹⁴ Art 12(1).

¹¹⁵ UN Committee on the Elimination of Discrimination Against Women (1999) A/54/38/Rev1, chap 1, General Recommendation no 24 para 25, available at <http://www.unhcr.org/refworld/docid/453882a73.html> (accessed 21 August 2012).

¹¹⁶ General Recommendation no. 24 para 25.

¹¹⁷ General Recommendation no.24 para 25.

¹¹⁸ Art 12(1)(2).

¹¹⁹ Art 16(1)(e).

counselling and services in family planning.¹²⁰ Women in rural areas must also benefit 'directly from social security programmes'.¹²¹

2.3 The development of Disability instruments at the international level

2.3.1 Introduction

In 1971 the UN General Assembly adopted a Declaration on the Rights of Mentally Retarded Persons.¹²² The declaration recognised that 'mentally retarded persons have the same rights as other human beings'; and the right of the mentally retarded person to 'proper medical care and physical therapy'.¹²³ In 1975 the General Assembly adopted a Declaration on the Rights of Disabled Persons.¹²⁴ The declaration recognised the right of disabled persons to 'medical, psychological and functional treatment, including prosthetic; to medical and social rehabilitation'.¹²⁵ The 1982 World Programme of Action concerning Disabled Persons recognised the effects of environment on disability.

2.3.2 World Programme of Action of 1982

In 1982 the UN General Assembly adopted a resolution; the 'World Programme of Action (WPA) concerning Disabled Persons'.¹²⁶ The WPA aimed at the prevention of disability, rehabilitation and the realisation of equal opportunities for disabled persons.¹²⁷ It further acknowledged that disability arises from a relationship between the disabled person and their environment;¹²⁸ while noting that disabled persons have equal rights and equal obligations.¹²⁹

The WPA acknowledges that health and social services for persons with mental disabilities have been neglected in many countries and suggest that 'psychiatric care of persons with mental illness be supplemented by the provision of social support and guidance to such persons as well as their families'.¹³⁰ For mental health services to reach the increasing numbers of persons with mental disabilities, the WPA recommends that such services be 'provided through various types of health and social workers in the local communities'.¹³¹

¹²⁰ Art14(2)(b).

¹²¹ Art 14(2)(c).

¹²² Quinn & Degener (n 89 above) 40.

¹²³ Declaration on the Rights of Mentally Retarded Persons (1971) General Assembly resolution 2856(XXVI)articles 1&2, available at <http://www2.ohchr.org/english/law/res2856.htm> (accessed 21 August 2012).

¹²⁴ Declaration on the Rights of Disabled Persons(1975)General Assembly resolution 3447(XXX),available at <http://www2.ohchr.org/english/law/res3447.htm> (accessed 21 August 2012).

¹²⁵ Declaration on the Rights of Disabled Persons para 6.

¹²⁶ World Programme of Action concerning Disabled Persons (1982) General Assembly resolution 37/52,available at <http://www.un.org/documents/ga/res/38/a38r028.htm> (accessed 22 August 2012).

¹²⁷ WPA para 1,

¹²⁸ WPA para 7.

¹²⁹ WPA para 26.

¹³⁰ WPA para 107.

¹³¹ WPA para 143; Paragraph 164 of the WPA directs bodies involved in the United Nations system who prepare international agreements or instruments with direct or indirect effect on disabled persons, to have regard to the situation of persons with disabilities.

2.3.3 UN Principles for the protection of persons with mental illness and the improvement of mental health care of 1991 (MI Principles)

In 1991, the General Assembly adopted the 'Principles for the protection of persons with mental illness and the improvement of mental health care'.¹³² The MI Principles define mental health care as including 'analysis and diagnosis of a person's mental condition and treatment, care and rehabilitation for a mental illness or suspected mental illness'.¹³³ The MI Principles recognise the right of all persons to the best available mental health care and prohibits discrimination on the grounds of mental illness.¹³⁴ Though the Principles did not explicitly mention women with mental disabilities, it states that 'every patient have the right to receive such health and social care as is appropriate to his or her health needs'.¹³⁵

However the Principles 'in some cases offer lesser protection than that offered by existing human rights treaties for example with reference to the requirement for prior informed consent to treatment',¹³⁶ where the MI Principles provide that treatment could be given without informed consent.¹³⁷ Also the Principles provides for compulsory institutionalisation which is an infringement of the right to liberty and security of person as well as the right to freedom of movement.¹³⁸

2.3.4 Standard Rules on the Equalization of Opportunities for Persons with Disabilities of 1993

In 1993, the United Nations General Assembly adopted the Standard Rules on the Equalization of Opportunities for Persons with Disabilities.¹³⁹ The Standard Rules gained their political and moral grounds from the Bill of Rights (Universal Declaration, ICCPR & ICESCR), CRC, CEDAW and the WPA.¹⁴⁰ Its purpose is to ensure that persons with disabilities exercise equal rights as other members of the society and therefore places the responsibility on States to take appropriate measures to remove barriers preventing persons with disabilities from enjoying their rights.¹⁴¹ States are also directed to pay 'special attention' to women with disabilities.¹⁴²

The Standard Rules urges states to ensure that 'persons with disabilities have access to relevant treatment methods and technology; and that 'they are provided with medicines needed to preserve or improve their level of functioning'.¹⁴³ An innovation of the Standard Rules was the creation of the office of the Special Rapporteur to monitor the implementation

¹³² General Assembly resolution 46/119 (1991).

¹³³ MI Principles definitions (c).

¹³⁴ MI Principles 1 & 4.

¹³⁵ MI Principle 8.

¹³⁶ Report of the UN Secretary-General 'Progress of efforts to ensure the full recognition and enjoyment of the human rights of persons with disabilities' (2002) A/58/181 para 12, available at <http://www.un.org/disabilities/default.asp?id=148> (accessed 6 October 2012).

¹³⁷ MI Principles 11 (6,7,8,13 &15).

¹³⁸ MI Principle 16

¹³⁹ General Assembly resolution 48/96(1993).

¹⁴⁰ Standard Rules para 13.

¹⁴¹ Standard Rules para 15.

¹⁴² Standard Rules para 15.

¹⁴³ Standard Rules rule 2(4)(6).

of the rules.¹⁴⁴ Although the Principles and the Standard Rules are not legally binding, they help create a standard for the treatment of persons with mental disabilities and thereby enable states to assess their level of compliance with international human rights standards on mental disability.¹⁴⁵

2.4 The UN Convention on the Rights of Persons with Disabilities

2.4.1 Background

In 2001, the UN General Assembly by a resolution established an Ad Hoc Committee to consider proposals for a comprehensive Convention on the Rights of Persons with Disabilities (CRPD).¹⁴⁶ The all-inclusive efforts of individuals, non-governmental organizations (NGOs), disability people's organisations (DPOs), and governmental representatives during the drafting and negotiations process culminated in the adoption of the CRPD with its Optional Protocol on 13 December 2006.¹⁴⁷ The most important aspect of the negotiation process was the participation of persons with disabilities who insisted that 'no decision be made about them without them'.¹⁴⁸ The need for the CRPD arose out of the failure of the existing human rights system to provide adequate protection to the specific needs of persons with disabilities.¹⁴⁹ This conclusion was informed by several events including the worldwide documentation of abuse against people with disabilities by two Special Rapporteurs appointed by the UN Human Rights Commission in the 1990's; Leandro Despouy and Erica-Irene Daes.¹⁵⁰

2.4.2 Features of the CRPD

Apart from being the first human rights treaty of the twenty-first century¹⁵¹ and specific to the needs of persons with disabilities, the CRPD is innovative in many respects. Firstly it represents a shift from the medical model of disability. Instead it adopts the social model¹⁵² and the human rights model which views persons with disabilities as 'right holders' rather than objects of charity and pity.¹⁵³ Secondly the CRPD embodies both civil and political

¹⁴⁴ Standard Rules sec 4(2).

¹⁴⁵ Gostin & Gable (n 83 above) 43.

¹⁴⁶ S Tromel 'A personal perspective on the drafting history of the United Nations Convention on the Rights of Persons with Disabilities' in G Quinn & L Waddington(eds) *European Yearbook of Disability Law* (2009)120.

¹⁴⁷ AS Kanter 'The promise and challenge of the United Nations Convention on the Rights of Persons with Disabilities'(2007) 34 *Syracuse Journal of International Law and Commerce* 287. The Convention was birthed after five years and within eight sessions of the ad hoc committee. See ML Perlin 'A change must come: The implications of the United Nations Convention on the Rights of Persons with Disabilities for the domestic practice of constitutional mental disability law(2009)29 *Northern Illinois University Law Review* 490.

¹⁴⁸ Perlin (n 147 above) 490

¹⁴⁹ Kanter (n 147 above) 294.

¹⁵⁰ Kanter (n 147 above) 307.

¹⁵¹ MA Stein& JE Lord 'Monitoring the Convention on the Rights of Persons with Disabilities: Innovations, lost opportunities, and future potential (2010) 32 *Human Rights Quarterly* 690.

¹⁵² Preamble (c) & article 1; S Quinlivan 'The United Nations Convention on the Rights of Persons with Disabilities: An introduction' (2012)13 *ERA Forum* 74.

¹⁵³ Kanter (n 147 above) 291. See UN Convention on the Rights of Persons with Disabilities (13 December 2006) A/RES/61/106,Annex 1,article 1 'The purpose of the present Convention is to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity'. The preamble of CRPD recognizes 'disability as resulting from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others', available at <http://www.unhcr.org/refworld/docid/480cd212.html> (accessed 22 August 2012).

rights and economic, social and cultural rights.¹⁵⁴ This is due to the fact that the CRPD recognises that all rights are universal, indivisible, interdependent and interrelated.¹⁵⁵

2.4.3 The right to mental healthcare under the CRPD

The CRPD in recognition of ‘the importance of accessibility to health in enabling persons with disabilities to fully enjoy all human rights and fundamental freedoms’,¹⁵⁶ makes ‘accessibility’ one of its general principles¹⁵⁷ as well as a substantive provision.¹⁵⁸ It provides that ‘facilities and services open or provided to the public be made accessible to persons with disabilities both in urban and rural areas; that the state must identify and eliminate barriers to such facilities which include medical facilities’.¹⁵⁹ Accessibility here is not limited to physical access but includes access to information.¹⁶⁰

2.4.4 Women’s right to mental healthcare under the CRPD

The CRPD admits that ‘women with disabilities are subject to multiple discrimination’.¹⁶¹ State Parties are obliged to recognize that ‘persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability; and to provide services that are gender-sensitive, including health-related rehabilitation’.¹⁶² The need to provide gender-sensitive health services has been recognised by the CEDAW Committee in its general recommendations.¹⁶³ Again the requirement by the CRPD of states to provide disability-specific health services ‘including early identification and intervention as appropriate, and services designed to minimize and prevent further disabilities’;¹⁶⁴ ‘close as possible to people’s own communities including rural areas’¹⁶⁵ implies that mental health care must be physically accessible to women with psycho-social disabilities. Habilitation and rehabilitation services are also to be made available to persons with disabilities as close as possible to their own communities,¹⁶⁶ and the state is to ‘promote the availability, knowledge and use of assistive devices and technologies, designed for persons with disabilities as they relate to habilitation and rehabilitation.’¹⁶⁷

Health care based on consent

¹⁵⁴ Quinlivan (n 152 above) 75.

¹⁵⁵ Preamble (c).

¹⁵⁶ Preamble (v).

¹⁵⁷ Art 3(f).

¹⁵⁸ Art 9.

¹⁵⁹ Art 9(1)(a).

¹⁶⁰ Art 9(2)(f).

¹⁶¹ Art 6(1).

¹⁶² Art 25.

¹⁶³ CEDAW Committee General Recommendation No 24. According to the CEDAW Committee, this is necessary since women differ from men due to biological, socio-economic and psycho-social factors.

¹⁶⁴ Art 25(b).

¹⁶⁵ Art 25(c).

¹⁶⁶ Art 26(1)(b)

¹⁶⁷ Art 26(3).

The provision of health services under the CRPD is based on ‘free and informed consent’.¹⁶⁸ In addition, the right to be free from torture or cruel, inhuman or degrading treatment or punishment under the CRPD prohibits medical or scientific experimentation without an individual’s free consent;¹⁶⁹ and directs states to ‘take all effective legislative, administrative, judicial or other measures to prevent persons with disabilities, on an equal basis with others, from being subjected to torture or cruel, inhuman or degrading treatment or punishment’.¹⁷⁰ The right to be free from non-consensual medical treatment has been recognised by the CESCRCR as one of the freedom components of the right to health.¹⁷¹ This implies that any mental health legislation that permits psychiatric interventions without a person’s consent is unlawful.¹⁷²

2.4.5 The nature of State obligations under the CRPD

All human rights impose three levels of obligations on states parties: the obligation to respect, protect and fulfil.¹⁷³ In this regard the CRPD aims to ‘promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity’.¹⁷⁴ The obligations arising under the CRPD have to be read with existing international law.¹⁷⁵

Obligation to respect

The obligation to respect the right to health requires the state to ‘refrain from denying or limiting equal access for all persons to preventive, curative and palliative health services’.¹⁷⁶ The CRPD recognises equality of opportunity, non-discrimination and accessibility as part of its underlying principles.¹⁷⁷ In light of this States Parties are to ‘prohibit all discrimination on the basis of disability and guarantee to persons with disabilities equal and effective legal protection against discrimination on all grounds’.¹⁷⁸ For a state to promote equality and eliminate discrimination, appropriate steps must be taken to ensure reasonable accommodation is provided.¹⁷⁹ However where specific measures necessary to accelerate or achieve de facto equality of persons with persons with disabilities is taken, such measures are not considered discriminatory.¹⁸⁰ Therefore when it comes to the provision of health

¹⁶⁸ Art 25(d).

¹⁶⁹ Art 15(1).

¹⁷⁰ Art 15(2).

¹⁷¹ General Comment No. 14 para 8; See T Minkowitz ‘United Nations Convention on the Rights of Persons with Disabilities and the right to be free from non-consensual psychiatric interventions’ (2007) 34 *Syracuse Journal of International Law and Commerce* 406.

¹⁷² As above.

¹⁷³ General Comment No 14 para 33.

¹⁷⁴ Art 1.

¹⁷⁵ Art 4(2).

¹⁷⁶ General Comment No 14 para 34.

¹⁷⁷ Art 3(b)(e)(f).

¹⁷⁸ Art 5(2).

¹⁷⁹ Art 5(3).

¹⁸⁰ Art 5(4).

services, the state is to 'provide persons with disabilities the same range, quality and standard of free or affordable health care and programmes as provided to other persons'.¹⁸¹

Obligation to protect

The obligation to protect requires states to adopt legislation or take other measures in realising the right.¹⁸² In line with this the CRPD requires state parties to adopt legislation and other measures to implement the rights enshrined therein.¹⁸³ The state is also to 'adopt appropriate measures such as legislation to modify or abolish existing laws, regulations, customs and practices that discriminate against persons with disabilities'.¹⁸⁴ Appropriate measures to eliminate discrimination on the basis of disability by any person, organization or private enterprise must also be taken by the state.¹⁸⁵ For instance with regards to the provision of health care services, the state is required to 'prohibit discrimination against persons with disabilities in the provision of health insurance where such insurance is permitted by national law, which shall be provided in a fair and reasonable manner'.¹⁸⁶ In addition to legislative measures, the ESCR Committee has commented that judicial remedies are granted with respect to those socio-economic rights which the state considers justiciable.¹⁸⁷

Obligation to fulfil

The obligation to fulfil means that a state implements laws and policies to give effect to the right to health.¹⁸⁸ When it comes to the fulfilment of socio-economic rights, the CRPD makes a distinction between those rights which are to be 'progressively realised and when needed within international cooperation' as well as those rights which can be 'immediately realised according to international law'.¹⁸⁹ This provision is similar to article 2 of the ICESCR which subjects socio-economic rights to progressive realisation.¹⁹⁰ The CESCR Committee has commented that states' obligations towards the right to health are both immediate and subject to progressive realisation.¹⁹¹ The immediate obligations here include the guarantee that the right will be exercised without discrimination of any kind and the obligation to take 'deliberate, concrete and targeted' steps towards the full realization of the right.¹⁹² Progressive realization was explained by the ESCR Committee as meaning 'a specific and continuing obligation to move as expeditiously and effectively as possible towards the full realization of the right to health'.¹⁹³ According to the ESCR Committee the core obligation of

¹⁸¹ Art 25(b).

¹⁸² General Comment No 14 para 35.

¹⁸³ Art 4(a).

¹⁸⁴ Art 4(b).

¹⁸⁵ Art 4(1)(e).

¹⁸⁶ Art 25(e).

¹⁸⁷ General Comment No. 3 para 5.

¹⁸⁸ General Comment No. 14 para 36.

¹⁸⁹ Art 4(3).

¹⁹⁰ Art 2(1).

¹⁹¹ General Comment No. 14 para 30.

¹⁹² General Comment No. 14 para 30.

¹⁹³ General Comment No 14 para 31.

states to provide minimum levels of socio-economic rights includes the obligation to ensure access to health facilities, goods and services on a non-discriminatory basis especially for vulnerable or marginalized groups.¹⁹⁴ Within the context of the CRPD, the right to non-discrimination¹⁹⁵ in the realisation of the right to access the health care and health services¹⁹⁶ is subject to immediate realisation. Thus women with psycho-social disabilities are guaranteed access to health care without discrimination and on an equal basis as other persons.

2.5 The guarantee of the rights of persons with mental disabilities within the African regional Human Rights system

The legal basis of the African regional human rights system, the African Charter on Human and Peoples' Rights (ACHPR) entered into force in 1986 and established the African Commission on Human and Peoples' Rights as its sole supervisory body (African Commission).¹⁹⁷ In 2004, the Protocol to the African Charter on Human and Peoples' Rights on the Establishment of the African Court on Human and Peoples' Rights entered into force.¹⁹⁸ Other important legal instruments adopted by the system include; the Protocol to the African Charter on Human and Peoples' Rights on the Rights of the Women in Africa (protocol on the rights of women) and the African Charter on the Rights and Welfare of the Child (African Children's Charter).¹⁹⁹ In addition to protecting civil and political rights as economic, social and cultural rights; one of the most notable features of the African Charter is its recognition of peoples' rights and the imposition of duties on individuals.²⁰⁰

2.5.1 The African Charter

The African Charter does not list disability as a prohibited ground of discrimination except that the inclusion of 'other status' can be read to include disability as adopted by the ESCR Committee.²⁰¹ In the case of *Purohit and another v The Gambia*, the African Commission decided that 'Article 2 lays down a principle that is essential to the spirit of the African Charter and is therefore necessary in eradicating discrimination in all its guises'.²⁰² This implies that discrimination on the basis of disability is prohibited by the African Charter. The *Purohit Case* is very important in the African context since it remains the only communication

¹⁹⁴ General Comment No 14 para 43 (a).

¹⁹⁵ Art 5.

¹⁹⁶ Art 25(f).

¹⁹⁷ C Heyns 'African Regional Human Rights System: The African Charter' (2004)108 *Penn State Law Review* 682.

¹⁹⁸ As above.

¹⁹⁹ Protocol to the African Charter on Human and Peoples' Rights on the Rights of the Women in Africa (2003/2005); African Charter on the Rights and Welfare of the Child (1990/1999) Compendium of key human rights documents of the African Union 2010.

²⁰⁰ M Ssenyonjo *The African regional human rights system* (2011) 456.

²⁰¹ General Comment No. 5 para 5.

²⁰² *Purohit and Another v The Gambia* (2003) AHLR 96 (ACHPR) para 49.

concerning the rights of persons with mental disabilities to be decided by the African Commission.²⁰³

2.5.2 The Right to health

The African Charter expressly provides for the ‘right of everyone to enjoy the best attainable state of physical and mental health’.²⁰⁴ In the *Purohit Case* where the complainants alleged that the Lunatic Detention Act of The Gambia coupled with the automatic and indefinite institutionalisation of persons with mental disabilities constituted disability-based discrimination; the African Commission decided that ‘the enjoyment of the human right to health as it is widely known is vital to all aspects of a person’s life and well-being, and is crucial to the realisation of all the other fundamental human rights and freedoms which includes the right to health facilities, access to goods and services to be guaranteed to all without discrimination of any kind’.²⁰⁵ Thus in *Free Legal Group and Others v Zaire* the African Commission decided that ‘the failure of the Government to provide basic services such as safe drinking water and electricity and the shortage of medicine constitutes a violation of the right to health’.²⁰⁶ Again, in the *Purohit Case*, the African Commission decided ‘that persons with mental illnesses should never be denied of their right to proper care, which is crucial for their assimilation into and acceptance by wider society’.²⁰⁷ The state’s obligation is to ‘take concrete and targeted steps, while taking advantage of its available resources, to ensure that the right to health is fully realised in all aspects without discrimination of any kind’.²⁰⁸

2.5.3 Right to liberty and security of person

The African Charter provides that every individual has the right to liberty and security of person and therefore no one may be denied of her freedom except for reasons laid down by law.²⁰⁹ This provision has implications when it comes to involuntary admissions of persons with mental disabilities.²¹⁰ However in the *Purohit Case*, the African Commission shied away from making very bold declarations concerning involuntary admissions. It decided that Article 6 of the African Charter ‘was not intended to cater for situations where persons in need of medical assistance or help are institutionalised’.²¹¹ This is very unfortunate as ‘an individual involuntarily admitted to a psychiatric institution and prevented from leaving would constitute detention within the ordinary meaning of the word’.²¹² Nevertheless, the African Commission

²⁰³ J Biegon ‘The promotion and protection of disability rights in the African human rights system’ in I Grobbelaar & T van Reen (eds) *Aspects of disability law in Africa* (2011) 70.

²⁰⁴ African Charter (1981/1986) article 16(1), Compendium of key human rights documents of the African Union 2010.

²⁰⁵ *Purohit and Another v The Gambia* para 80.

²⁰⁶ *Free Legal Assistance Group and Others v Zaire* (2000) AHRLR 74 (ACHPR 1995) para 47.

²⁰⁷ *Purohit and Another v The Gambia* para 85.

²⁰⁸ *Purohit and Another v The Gambia* para 84.

²⁰⁹ Art 6.

²¹⁰ Minkowitz (n 171 above) 406.

²¹¹ *Purohit and Another v The Gambia* para 68.

²¹² Bartlett P & Hamzic V ‘Reforming mental disability law in Africa: Practical tips and suggestions’ (2010) 8 Human Rights Law Centre, available at

decided that Article 7 of the African Charter entitles persons admitted involuntarily to an independent hearing and therefore ordered the Gambian government to establish a body of experts to review the cases of all persons detained under the Lunatics Detention Act and make appropriate recommendations for their treatment or release.²¹³

2.5.4 Right to special measures

Article 18(4) of the African Charter provides that ‘the aged and the disabled shall also have the right to special measures of protection in keeping with their physical or moral needs’. Therefore in the *Purohit Case*, the African Commission decided ‘that in keeping with article 18 (4) and the MI Principles, by virtue of their disabilities, mental health patients should be accorded special treatment which would enable them not only attain but sustain their optimum level of independence and performance.’²¹⁴ By reason of the requirement to be accorded special treatment, the African Commission held that ‘the Lunatics Detention Act is lacking in terms of therapeutic objectives as well as provision of matching resources and programmes of treatment of persons with mental disabilities.’²¹⁵

Article 18(4) emphasizes substantive equality and thereby severs the link with formal equality.²¹⁶ However the putting together of two distinct groups under Article 18(4) creates the likelihood of the distinct needs and rights of the two groups not receiving the attention they deserve.²¹⁷

2.5.5 The African Women’s Protocol

The Protocol on the Rights of Women which entered into force in 2005 guarantees the rights of women with disabilities. The Protocol prohibits discrimination against women generally and specifically on the ground of disability.²¹⁸ States are to ‘enact and implement legislation that prohibit all forms of discrimination particularly those harmful practices which endanger the health and well-being of women’.²¹⁹ Article 5(b) identifies some of the harmful practices which affect the health of women to include, female genital mutilation and scarification.²²⁰ Research has shown that women who go through female genital mutilation have a higher probability of developing mental disabilities than other women.²²¹ This is due to the fact that female genital mutilation could result in emotional disturbances such as post-traumatic disorder.²²² The Protocol require States to provide victims of harmful practices with ‘health services, emotional and psychological counselling’.²²³ The rights to life, integrity and security

<http://www.nottingham.ac.uk/hrlc/documents/publications/reformingmentaldisabilitylawinafrica.pdf> (accessed 9 October 2012).

²¹³ *Purohit and Another v The Gambia* para 72.

²¹⁴ As above para 81.

²¹⁵ *Purohit and Another v The Gambia* para 83.

²¹⁶ *Biegon* (n 203 above) 63.

²¹⁷ As above.

²¹⁸ Arts 2 & 23(b).

²¹⁹ Art 2(b).

²²⁰ Art 5(b)

²²¹ A Behrendt & S Moritz ‘Posttraumatic stress disorder and memory problems after female genital mutilation’ (2005)162 *The American Journal of Psychiatry* 1000.

²²² Behrendt & Moritz (n 221 above)1001.

²²³ Art 5(c).

of the person under the Protocol prohibit all medical or scientific experiments on women without their consent.²²⁴

Article 14 of the Protocol recognise the right to health of women as including sexual and reproductive health; State parties are to provide adequate, affordable and accessible health services'.²²⁵ The Protocol authorises 'medical abortion in cases rape, sexual assault, incest and where the continued pregnancy endangers the mental and physical health of the mother or the life of the foetus'.²²⁶ This provision is very progressive in the context of Africa where 30 000 women die each year from unsafe-abortion-related deaths.²²⁷ Most of the women who undergo unsafe abortions suffer 'illness and disability'.²²⁸ Therefore the provision of access to safe abortions could serve as one of the measures to prevent disability among women.

In the context of women with disabilities, the Protocol puts an obligation on state parties to ensure the protection of women with disabilities and take specific measures commensurate with their physical, economic and social needs to facilitate their access to employment, professional and vocational training as well as their participation in decision-making.²²⁹

2.6 The protection of the rights of persons with mental disabilities within the African sub regional Human Rights system- SADC.

The Southern African Development Community (SADC) was established among other objectives, to 'promote economic integration to facilitate growth and poverty alleviation in the sub-region'.²³⁰ Despite its economic focus the SADC has broadened the scope of its mandate to include human rights, specifically the rights of persons with disabilities.²³¹ Thus the SADC treaty prohibits discrimination on a number of grounds including gender and disability.²³² This treaty would be an effective tool in combating discrimination against women with psycho-social disabilities since it prohibits multiple discrimination.

2.6.1 SADC Protocol on Gender and Development

This Protocol was adopted in 2008 to 'provide for the empowerment of women, to eliminate discrimination and to achieve gender equity and equality through gender responsive legislation, policies and programmes'.²³³ Therefore states are to review or repeal laws that discriminate based sex or gender by 2015;²³⁴ and 'eliminate practices which are detrimental

²²⁴ Art 4(h).

²²⁵ Arts 14(1) &(2)(a).

²²⁶ Art 14(c).

²²⁷ CG Ngwena 'Protocol to the African Charter on the Rights of Women: implications for access to abortion at the regional level' (2010)110 *International Journal of Gynaecology and Obstetrics* 164.

²²⁸ As above.

²²⁹ Art 23.

²³⁰ SADC Treaty (2009) as amended article 5(1)(a), available at <http://www.sadc.int/index/browse/page> (accessed 9 October 2012).

²³¹ Biegon (n 203 above) 67.

²³² Art 6(2).

²³³ Art 3(a).

²³⁴ Art 6(1).

to the achievement of the rights women by prohibiting such practices and attaching deterrent sanctions'.²³⁵ State Parties under Article 9 undertake to adopt legislation and related measures to protect persons with disabilities that take into account their particular vulnerabilities. The wording of this provision makes it generally applicable to persons with disabilities and not women with disabilities in particular as the Protocol by its caption makes one believe.²³⁶ Also the wording here implies that persons with disabilities are in need of social welfare and may perpetuate the stigma associated with persons with disabilities as being objects of pity. When it comes to health, the Protocol requires that states develop and implement policies and programmes to address the mental, sexual and reproductive health needs of women.²³⁷ Thus this Protocol has the potential of addressing the barriers to the right to access mental health care of women with psycho-social disabilities which include discrimination.

2.6.2 SADC Protocol on Health

The Protocol was adopted in 1998 to promote cooperation among states in 'addressing the health problems and challenges facing them'.²³⁸ It makes provision for persons with disabilities in general and mental health in particular.²³⁹ Disability is defined under the Protocol as 'any restriction or lack of ability to perform an activity in the manner or within the range considered normal for a human being'.²⁴⁰ This definition focuses unnecessarily on a person's impairment and tends to categorise a person with disability based on his or her inabilities. It therefore follows the medical model. Based on its narrow focus, the Protocol enjoins states to 'promote effective measures to prevent and manage disabilities'.²⁴¹ However the Protocol encourages states to 'increase access to improved technology related to assistive devices, to remove barriers to equal opportunities for persons with disabilities and to promote community-based rehabilitation programmes'.²⁴² With respect to mental health, the Protocol recognises the importance of mental health to sustained human and economic growth and therefore obliges states to develop compatible mental health legislation; integrate mental health services into primary health care; provide proper treatment and care commensurate with the dignity and human rights of persons with mental disabilities; develop community care services and facilities; and cost-effective and culture specific mental health research.²⁴³

²³⁵ Art 6(2)(c).

²³⁶ Biegon (n 203 above)66.

²³⁷ Art 26(b).

²³⁸ Art 3.

²³⁹ Arts 15& 22.

²⁴⁰ Art 1.

²⁴¹ Art 15(a).

²⁴² Art 15(b)(c)(d).

²⁴³ Art 22.

2.7 Conclusion

The international law guarantees of the right to physical and mental health includes the provision of appropriate mental health treatment and care without discrimination based on disability. The adoption of UN Disability instruments such as the UN Declaration of the Rights of Mentally Retarded Persons; the World Programme of Action and the MI Principles broadened the scope of mental health care to include social care and rehabilitative services. The Standard Rules recognised the equal rights of persons with disabilities and called on States to remove barriers to the enjoyment of the rights by persons with disabilities; while granting access to relevant treatment, methods and technology. These treaties are not legally binding but they made an impact in improving the state of persons with disabilities internationally. The adoption of the CRPD saw to the welcoming of the first international disability-specific treaty with new guarantees for the rights of persons with disabilities generally and women with psycho-social disabilities specifically. The CRPD provides for the right to health which responds to women's mental health care needs. Mental health care must be physically accessible; economically affordable and any relevant mental health information must be made accessible. The state has the obligation to respect, protect and fulfil the right to mental health care. The African Commission with its ground-breaking decision in *Purohit v The Gambia*, made progressive declarations about the African Charter's guarantee of the right to health of persons with mental disabilities; albeit not very bold in terms of involuntary admissions of persons with mental disabilities. The SADC recognises the right of persons with disabilities to health and directs States parties to enact mental health legislation to safeguard this right.

Chapter three: Legal and policy framework in South Africa

3.1 Introduction

This chapter discusses the laws and policies guaranteeing the right to access health care by women with psycho-social disabilities in South Africa. It provides a brief history of mental health care in South Africa, developments in legislation guaranteeing the rights of persons with mental disabilities generally and women with psycho-social disabilities specifically. It will explore the constitutional guarantees of the right to access mental health care, the current Mental Health Act 2003; National Health Act 2003; and governmental policies implementing mental health care in South Africa.

3.2 A brief history of mental health care in South Africa

From earlier times, especially in the mid-19th century, persons with mental disabilities in South Africa were institutionalised permanently in order ‘minimise their impact on society and to prevent them from procreating and passing on undesirable characteristics’.²⁴⁴ In 1910, there were eight mental institutions with the capacity to accommodate about 1 692 white and 1 932 black, coloured and Indian patients.²⁴⁵ These institutions which were modelled after the British system were like prisons, overcrowded and lacked therapeutic treatment; though in all cases white patients had better treatment than black patients.²⁴⁶ In the early 20th century, though mental health care facilities accommodated more persons services still remained limited.²⁴⁷

During Apartheid, South Africa was classified as one of the most ‘psychologically ill societies in the world’, marked by ‘repression, human rights abuse, violence, alcohol-related problems, malnutrition and poverty’.²⁴⁸ Persons with disabilities were faced with inequalities depending on their race and discrimination as a result of their impairment.²⁴⁹ For instance for most black people with disabilities, ‘their daily struggle to cope with poverty, deprivation and violence was compounded by their disability’.²⁵⁰

Black people with mental disabilities ‘were often denied mental health care services’.²⁵¹ Their treatment often consisted of ‘institutionalization in inadequate facilities’ and on ‘inaccurate notions’ such as ‘black people were subject to permanent and untreatable disorders like schizophrenia, paranoia and epileptic psychosis, while white people were more inclined to manic-depressive psychosis, neurosis and defective mental development which

²⁴⁴ S Horwitz Health and health care under Apartheid (2009)11.

²⁴⁵ As above.

²⁴⁶ As above.

²⁴⁷ As above.

²⁴⁸ As above.

²⁴⁹ C Howell et al ‘A history of the disability rights movement in South Africa’ in B Watermeyer et al (eds) *Disability and social change: A South African agenda* (2006) 60.

²⁵⁰ As above.

²⁵¹ Horwitz (n 244 above) 11.

were considered to be less severe'.²⁵² Mental institutions were in deplorable conditions which did not foster mental health.²⁵³

3.3 Development of legislation guaranteeing the rights of persons with mental disabilities in South Africa

3.3.1 Legislation to regulate mental health care

In 1973, the Mental Health Act 18 was passed to 'provide for the reception, detention and treatment of persons who are mentally ill; and to provide for incidental matters'.²⁵⁴ The 1973 Mental Act was enacted out of 'public panic' following the assassination of Prime Minister Dr. Hendrik French Verwoerd by someone thought to have a mental disability²⁵⁵ and 'a resurgence of confidence in the scientific capabilities of psychiatry'.²⁵⁶ A Commission tasked to enquire into the assassination reported that

It is probable that a large number of assassinations, if not the majority, are committed by mentally disordered persons. They are pre-eminently the ones who could be used to commit a murder.²⁵⁷

As a result a second Commission was appointed in 1967 to investigate how effective the law concerning the 'prevention of dangerous acts by mentally disordered persons' was.²⁵⁸ After that a third Commission was proposed to look into the Mental Disorders Act of 1916, culminating into the enactment of the Mental Health Act of 1973.²⁵⁹

The Mental Health Act of 1973

The Act defined 'mental illness' as 'any disorder or disability of the mind, and includes any mental disease and any arrested or incomplete development of the mind, and 'mentally ill' has a corresponding meaning'.²⁶⁰ This definition which was substituted by s 8(a) of Act No. 116 of 1993 included persons having 'any psychopathic disorder' to the definition of mental illness as provided by the Mental Health Act of 1973. With regards to mental health care, the Act focused on institutionalisation by providing for categories of persons with mental disabilities to be institutionalised such as 'voluntary patients,²⁶¹ mentally ill persons who are dangerous,²⁶² State patients and mentally ill prisoners'.²⁶³ The rationale behind the shift to 'incarceration' was the belief that 'confinement constituted treatment'.²⁶⁴ Due to this, the Act

²⁵² As above 11.

²⁵³ Horwitz (n 244 above) 12.

²⁵⁴ Act 18 of 1973 preamble.

²⁵⁵ NL McCrea 'An analysis of South Africa's mental health legislation' (2010) National Law Forum available at <http://www.natlawreview.com> (accessed 18 September 2012) pg 2.

²⁵⁶ N Haysom et al 'The mad Mrs Rochester revisited: the involuntary confinement of the mentally ill in South Africa' (1990) 6 *The South African Journal on Human Rights* 342.

²⁵⁷ Report of the Commission of Inquiry into the Circumstances of the Death of the late Hon. Dr H F Verwoerd under Justice JJ van Wyk, RP 16/1967 (The Verwoerd Commission) as cited by Haysom et al (n 253 above) 343.

²⁵⁸ Haysom et al (n 256 above) 343.

²⁵⁹ As above.

²⁶⁰ Act 18 of 1973.

²⁶¹ Sec 3.

²⁶² Sec 8.

²⁶³ Sec 28.

²⁶⁴ Haysom et al (n 256 above) 343; Petersen I et al 'Planning for district mental health services in South Africa: a situational analysis of a rural district site' (2008) 24 *Health Policy and Planning* 140.

was criticised for not having ‘an individual rights’ perspective and rather focused on ‘control and treatment’ as well as the ‘welfare and safety of the society’.²⁶⁵ Moreover, the Mental Health Act of 1973 helped perpetuate distinctions in mental health care standards based on race and increased the level of stigma faced by persons with mental disabilities.²⁶⁶ In the end the Mental Health Act of 1973 did not provide any guarantees for the rights of persons with mental disabilities.

3.3.2 Democratic dispensation and the rights of persons with mental disabilities

In 1994, South Africa saw the coming to office of the first democratically elected government and the establishment of a constitutional assembly, leading to the adoption of a new constitution in 1996.²⁶⁷ The 1996 Constitution not only guaranteed the basic human rights of all persons and disadvantaged groups but also provided the basis for many legislative reforms.²⁶⁸

The 1996 Constitution prohibits discrimination on the basis of disability, gender, sex, pregnancy,²⁶⁹ and guarantees equal protection of the law for all persons.²⁷⁰ Equality means that the substantive provisions of the law should be applied equally to everyone. This provision does not however prevent a government from classifying people; where such classifications are legitimate.²⁷¹ The right to equality is linked to the right to dignity; this means that where classifications affect the dignity of a person, it violates his right to equality.²⁷² Article 12 of the 1996 Constitution provides for the right to freedom and security of person which includes the right not to be deprived of freedom arbitrarily or without a just cause.²⁷³ Thus where persons with mental disabilities are subjected to involuntary treatment, it violates their right to freedom and security of person as well as their right to dignity and equality. These rights are not absolute and may be limited in terms of section 36 of the 1996 Constitution.

The right to access health care under the 1996 Constitution

The Constitution guarantees the right to have access to health care services including reproductive health care and social security as well as emergency medical treatment.²⁷⁴ Section 27 confers both ‘freedoms and entitlements’.²⁷⁵ By conferring freedoms, ‘it ensures that in a liberal democracy’ all persons regardless of their characteristics can pursue their

²⁶⁵ McCrea (n 255 above) 2.

²⁶⁶ McCrea (n 255 above) 343.

²⁶⁷ Dube KA ‘The role and effectiveness of disability legislation in South Africa’ (2005)15.

²⁶⁸ As above.

²⁶⁹ Sec 9(3).

²⁷⁰ Sec 9(1).

²⁷¹ K Govender ‘The equality provision, unfair discrimination, and affirmative action’, Department of Public Law, University of Natal, Durban, 2.

²⁷² As above.

²⁷³ Sec 12(1)(a).

²⁷⁴ Sec 27(a),(c)&3.

²⁷⁵ C Ngwenya & R Cook ‘Four/rights concerning health’ in D Brand & CH Heyns (eds) Socio-economic rights in South Africa (2005)131.

right to access health care services in the 'state and private sectors'.²⁷⁶ In the process it guarantees the rights to equality and human dignity²⁷⁷ while ensuring that access to health care services is provided in a non-discriminatory manner.²⁷⁸ The section also provides for reproductive health care which is extremely important for women 'who in the past have constituted a vulnerable and disadvantaged class' for instance in cases of access to abortion.²⁷⁹

Interpretation of section 27 of the Constitution

The cases discussed here do not directly relate to mental health care services but instead are relevant to an understanding of section 27.

Soobramoney v Minister of Health Kwazulu-Natal

The duty to fulfil the right to have access to health care services under section 27 of the Constitution falls on the state. Section 27(2) provides that 'the state must take reasonable legislative and other measures, within its available resources to achieve the progressive realisation of these rights'.²⁸⁰ In the case of *Soobramoney v Minister of Health Kwazulu-Natal*²⁸¹ the Constitutional Court interpreted the scope and content of the right of access to health care services as provided under sections 27(1)(b) and 27(3).²⁸² The appellant in this case suffered from kidney failure and required dialysis. He was however refused to be admitted to the dialysis program of the Addington state hospital as he did not qualify per the hospital's guidelines. The Constitutional Court held that 'the obligations imposed by section 27 are dependent upon the availability of resources and that the right is limited by reason of lack of resources'.²⁸³ The Court further held that section 27(3) which provides for emergency medical treatment is intended to 'ensure that treatment be given in an emergency and is not frustrated by reason of bureaucratic requirements or other formalities'.²⁸⁴ Therefore the Court was of the view that the appellant's condition which required renal dialysis two to three times a week did not constitute an emergency for 'remedial treatment'.²⁸⁵ Moreover due to insufficient funds the guidelines assisted in deciding who should receive treatment or not.²⁸⁶ In effect with regards to the state's duty under sec 27 'the needs of the larger society should

²⁷⁶ As above.

²⁷⁷ As above.

²⁷⁸ Sec 9(4).

²⁷⁹ For example the Abortion and Sterilization Act of 1975 discriminated unfairly against women in practice by spelling out very narrow conditions under which abortions may be obtained restricting access to abortion so that 'only well resourced and women in urban areas' could benefit from the Act. See C Ngwenya & R Cook 'Four/rights concerning health' in Brand & Heyns (n 272 above)132; S Guttmacher et al 'Abortion reform in South Africa: A case study of the 1996 Choice on Termination of Pregnancy Act (1998) 24 *International Family Planning Perspectives* 192; RE Mhlanga 'Abortion: Developments and impact in South Africa'(2003)67 *British Medical Bulletin* 116.

²⁸⁰ Sec 27(2).

²⁸¹ *Soobramoney v Minister of Health (Kwazulu-Natal)* 1998 1 SA 765.

²⁸² M Swanepoel 'Human rights that influence the mentally ill patients in South African medical law: A discussion of sections 9; 27; 30 & 31(2011) *Potchefstroom Electronic Law Journal* 48.

²⁸³ *Soobramoney v Minister of Health* para 11.

²⁸⁴ *Soobramoney v Minister of Health* para 20.

²⁸⁵ *Soobramoney v Minister of Health* para 21.

²⁸⁶ *Soobramoney v Minister of Health* para 24.

be the focus rather than few individuals'.²⁸⁷ The appeal was not granted. This case has been criticised based on its judicial reasoning rather its outcome.²⁸⁸ Firstly its interpretation of section 27(3) as a 'negative right rather than a positive right gives the impression that sec 27(3) does not impose any obligations on the state or health care providers to develop and make available emergency services'.²⁸⁹ Secondly apart from the fact that the Court failed to establish the normative content of the right under sec 27(1)(a); it left the provincial or national health care provider to set limits to how far the right to access health care services could be realised.²⁹⁰

Minister of Health and Others v Treatment Action Campaign (TAC) and Others

This case was an appeal against the decision of the High Court where the applicants had challenged the government's decision to restrict access to an antiretroviral drug called nevirapine which was necessary to prevent mother-to-child transmission of HIV.²⁹¹ The Court in this case was to decide whether the applicants have shown that the measures adopted by the government fell short of its obligations under the Constitution.²⁹² The Constitutional Court rejected a minimum core argument by stating that 'it is impossible to give everyone access to a core service immediately. That all that can be expected of the state is that it acts reasonably to provide access to socio-economic rights in sections 26 and 27 on a progressive basis'.²⁹³ These two, sec 27(1) and sec 27(2) must be read together as defining the scope of the rights as well as the obligations on the state'.²⁹⁴ The Court found the government to have breached its obligations under sec 27(2) as its policy denied mothers and their newborn children who were outside the pilot sites from having access to a life-saving drug that could have been provided within the state's available resources.²⁹⁵ The government's policy was also found not to reasonable.²⁹⁶ Though the approach taken by the Court in this case allows every case to be decided on its merit, it 'may have the effect of inadvertently failing sufficiently to impress upon the state the compelling nature of socio-economic rights obligations'.²⁹⁷

The judgments in these cases imply that in the context of mental health care provision, regard would be given to mental health care service required by the entire population rather than some few individuals. In the case of women with mental disabilities whose experience of mental disability is peculiar due to their biological make up, their mental health needs are likely to be overlooked; while provision is made for the more general needs of the population.

²⁸⁷ *Soobramoney v Minister of Health* para 31.

²⁸⁸ Ngwena & Cook (n 275 above) 135.

²⁸⁹ 1 Ngwena & Cook (n 275 above) 36.

²⁹⁰ Ngwena & Cook (n 275 above) 137.

²⁹¹ *Minister of Health and Others v TAC and others* 2002 10 BCLR 1033(CC) para 2.

²⁹² *Minister of Health and Others v TAC and others* (n 291 above) para 25.

²⁹³ *Minister of Health and Others v TAC and others* (n 291 above) para 35.

²⁹⁴ *Minister of Health and Others v TAC and others* (n 291 above) para 39.

²⁹⁵ *Minister of Health and Others v TAC and others* (n 291 above) para 80.

²⁹⁶ *Minister of Health and Others v TAC and others* (n 291 above) para 81.

²⁹⁷ Ngwena & Cook (n 275 above) 143.

Moreover where the decision as regards mental health care provision is left to a Department of Health to decide without the input of the women who need those services, the mental health needs of women may not be met. The court would approve of the policies of the state so long as they are reasonable.

3.3.3 Further legal and policy reform impacting on health

Despite the safeguards created by the 1996 Constitution, there were still laws that failed to protect the rights of persons with disabilities;²⁹⁸ such as the Mental Health Act of 1973. In 1997, the South African government in collaboration with various organisations representing persons with disabilities produced the Integrated National Disability Strategy White Paper (INDS). The INDS proposed the 'development of a comprehensive universal health care system, at primary, secondary and tertiary level, that is sensitive to the general and specific health care needs of people with disabilities'.²⁹⁹ It also proposed that health care must provide rehabilitation which should include the following components; medical, psychological and educational rehabilitation.³⁰⁰

White Paper for the transformation of the health system in South Africa

The State made efforts to restructure the health system with primary health care being the focus.³⁰¹ This was contained in the White Paper produced by the Department of Health in 1997.³⁰² The White Paper acknowledged that 'mental health promotion and the provision of services had been neglected in the past and had been fragmented'.³⁰³ As a result services could not reach many people especially in rural areas.³⁰⁴ As its underlying principle, the White Paper proposed 'a comprehensive and community-based mental health and related service at the national, provincial, district and community levels; and the integration of mental health services into primary health care'.³⁰⁵ The policy guidelines of the White Paper are reflected in sections 3 and 4 of the Mental Health Care Act (MHCA) which was passed in 2002.

3.3.4 The Mental Health Care Act (MHCA) 17 of 2002

The MHCA was enacted in 2002 and implemented in 2004.³⁰⁶ It is to provide for the 'care, treatment and rehabilitation'³⁰⁷ of persons with mental health problems and states that 'mental health services should be provided as part of primary, secondary and tertiary health

²⁹⁸ Government of South Africa 'Integrated National Disability Strategy White Paper' (1997), available at <http://www.info.gov.za/whitepapers/1997/disability.htm> (accessed 1 October 2012).

²⁹⁹ Government of South Africa 'Integrated National Disability Strategy White Paper' (n 296 above) chapter 3.

³⁰⁰ As above.

³⁰¹ Petersen et al (n 264 above) 141.

³⁰² Department of Health 'White Paper for the transformation of the health system in South Africa' (1997), available at <http://www.doh.gov.za/show.php?id=3189> (accessed 30 September 2012).

³⁰³ Department of Health (n 302 above) chapter 12.

³⁰⁴ As above.

³⁰⁵ As above.

³⁰⁶ Rensburg VJ 'A framework for current public mental health care practice in South Africa' (2007)10 *African Journal of Psychiatry* 205.

³⁰⁷ MHCA 17 of 2002.

services'.³⁰⁸ Apart from these, the MHCA seeks to promote the human rights of persons with mental disabilities and provides that 'the person, human dignity and privacy of every mental health care user must be respected',³⁰⁹ a 'mental health care user may not be unfairly discriminated against on grounds of his or her mental health status' and is to be protected from 'exploitation and abuse'.³¹⁰

The MHCA defines mental illness as 'a positive diagnosis of a mental health related illness in terms of accepted diagnostic criteria made by a mental health care practitioner authorised to make such diagnoses'.³¹¹ It aims to regulate mental health care in a way that makes the best possible mental health care; to make treatment and rehabilitation services available to the population equitably, efficiently and in the best interest of mental health care within the limits of available resources; to 'co-ordinate access to mental health care, treatment and rehabilitation services to various categories of mental health care users' and integrate the provision of mental health care into general health care.³¹² This implies that women with psycho-social disabilities should have access to mental health care within the primary health care system.

Some important provisions in Mental Health Care Act 2002

The MHCA protects the rights of persons with mental disabilities while ensuring that they receive the care, treatment and rehabilitation services required by their mental health status and may intrude only as little as possible to give effect to the appropriate care, treatment and rehabilitation.³¹³

Voluntary Treatment

The MCHA guarantees the rights of persons who agree to voluntary treatment. It provides that 'a mental health care user who submits voluntarily to a health establishment for care, treatment and rehabilitation services, is entitled to appropriate care, treatment and rehabilitation services or to be referred to an appropriate health establishment'.³¹⁴

Involuntary Treatment

Section 33 of the MHCA states that for a person to be involuntarily committed, 'an application would have to be made by the parent, associate, parent or guardian of the user',³¹⁵ who must have seen the mental health care user within seven days before making the application'.³¹⁶ On receipt of the application, the head of the health establishment concerned is to cause the health care user to be examined by two mental health care practitioners,³¹⁷ who must report their findings to the head of the health establishment whether the requirements had been

³⁰⁸ Preamble..

³⁰⁹ Sec 8(1).

³¹⁰ Secs 10 & 11.

³¹¹ Definitions.

³¹² Sec 3(a).

³¹³ Sec 8(3).

³¹⁴ Sec 25.

³¹⁵ Sec 33(1).

³¹⁶ Sec 33(1)(b).

³¹⁷ Sec 33(4)(a).

duly followed and whether involuntary care is necessary in the present circumstances.³¹⁸ However if the findings of the two practitioners differ, another mental health care practitioner is must examine the healthcare user³¹⁹ as the application can only be approved where there is consensus among two mental health practitioners.³²⁰

In a case where the head of the health establishment approves the application, the mental health care user must be admitted within 48 hours³²¹ and given care.³²² After this the mental health care user must be examined by another mental health practitioner for a period of 72 hours to establish whether the involuntary care must be continued.³²³ If involuntary care is necessary, the review board must be informed in writing.³²⁴ The MCHA allows the applicant or the mental health care user to appeal the decision of the head of health establishment to the Review Board within 30 days³²⁵ with a further appeal to the High Court.³²⁶ Nevertheless where a person is committed, six months after care, treatment and rehabilitation has started and every 12 months after that, the head of the health establishment must cause the status of the mental health care user to be reviewed and a report must be submitted to the Review board.³²⁷

These provisions are significant as they establish a move away from institutionalised care as the first option in mental health care and employs a stringent process to hospitalise a mental health care user; subject to appeals and periodic reviews.

Intervention by the Police

Members of the South African Police are empowered to make arrests of any person who the police officer believes from personal observation or information obtained from a mental health practitioner, that the person due to his or her mental disability is likely to cause harm to herself or others.³²⁸ After the arrest has been carried out, the police are to take the person to the appropriate health facility for an assessment of the person's mental health status to be carried out.³²⁹ Where the assessment establishes that the persons is likely to cause harm to himself or herself due to 'mental illness', the person must be admitted for not more than 24 hours for an application to obtain involuntary care to be made.³³⁰ However where it is established that the person is not likely to cause harm to herself or to others, she must be released immediately.³³¹ When a state patient absconds or is deemed to have absconded

³¹⁸ Sec 33(5)(a)(b).

³¹⁹ Sec 33(6)(a).

³²⁰ Sec 33(7).

³²¹ Sec 33(9)(a).

³²² Sec 34(1)(a)

³²³ Sec 34(b).

³²⁴ Sec 34(3)(b)(ii).

³²⁵ Sec 35(1).

³²⁶ Sec 36.

³²⁷ Sec 37(1)&(3)

³²⁸ Sec 40(1).

³²⁹ Sec 40(1)(a).

³³⁰ Sec 40(2)(a).

³³¹ Sec 40(2)(b).

the Police is to be notified and requested to locate, apprehend and return the patient to the health facility.³³²

State Patients

The Criminal Procedure Act 51 of 1977 provides that where a court finds that an accused person is not capable of understanding the proceedings so as to make a proper defence is charged with murder or homicide or rape and the court considers it to be necessary in the public interest or that the accused has committed the act in question, the court is to order for the detention of the accused in a psychiatric hospital or prison pending the decision of a judge in terms of section 29(1)(a) of the Mental Health Act, 1973.³³³ Where the accused person has a 'mental illness' and is found by the court to have committed the crime in question, the court shall not find the person guilty but shall direct that the accused be detained in a psychiatric hospital or prison pending the decision of a judge in terms of section 29 of the Mental Health Act, 1973.³³⁴ The accused may also be treated as an 'outpatient pending the certification by the superintendent of that institution stating that he or she need no longer be treated as such'.³³⁵ The Mental Health Act of 1973 is no longer in force and therefore the MHCA of 2002 has rules concerning accused persons.

The MCHA provides that where a court order has been issued in terms of the Criminal Procedure Act for a state patient to be committed, the Registrar must send a copy to the official curator and the relevant officer in charge of the detention centre where the state patient is or will be detained.³³⁶ The officer in charge of the detention centre must within 14 days of being notified, see to the transfer of the state patient to the health facility in the notice.³³⁷

Mentally ill prisoners

Section 49 the MHCA directs heads of the national and provincial departments to 'designate health establishments which may admit, care for, treat and provide rehabilitation services to mentally ill prisoners'.³³⁸ After an enquiry has been made by a psychiatrist or a medical practitioner and a mental health care practitioner to establish the mental health status of a prisoner,³³⁹ a report is made to that effect, including a plan for the care, treatment and rehabilitation of that prisoner.³⁴⁰ Where the person conducting the enquiry finds that 'the mental illness of the prisoner is of such a nature that the prisoner could appropriately be cared for, treated and rehabilitated in prison, the head of the prison is to ensure that the prisoner receives the required levels of care'.³⁴¹ However if the prisoner requires care and

³³² Sec 44(1)(a).

³³³ Sec 77(6)(a)(i)(ii).

³³⁴ Sec 78(6)(b)(i)(aa).

³³⁵ Sec 78(6)(b)(i)(cc).

³³⁶ Sec 42(1)(a)(b).

³³⁷ Sec 42(4).

³³⁸ Sec 49.

³³⁹ Sec 50(1).

³⁴⁰ Sec 50(2).

³⁴¹ Sec 51.

treatment in a health establishment, 'the head of the prison must request a magistrate to cause a subsequent enquiry to be conducted into the mental health status of the prisoner as to whether a transfer to a designated health establishment would be appropriate'.³⁴² The magistrate is to commission two mental health care practitioners to make recommendations as to whether the prisoner should be transferred to the designated health establishment.³⁴³ If the prisoner need not be cared for in a health establishment the magistrate must issue a written order to the head of the prison to ensure the required levels of care and treatment are provided to the prisoner.³⁴⁴

Mental Health Review Boards

The MHCA establishes Review Boards for every establishment providing mental health care, treatment and rehabilitation services in every province.³⁴⁵ Its composition is diverse; a mental health care practitioner, magistrate, an attorney or advocate and a member of the community.³⁴⁶ The board is empowered among others, to 'consider appeals against decisions of the head of a health establishment; make decisions with regard to assisted or involuntary mental health care; consider applications for transfer of mental health care users to maximum security facilities; and consider periodic reports on the status of prisoners who are mentally ill'.³⁴⁷ A member of the Review Board may be removed from office for a number of reasons including 'public interest'.³⁴⁸

The National Health Act (NHA) 61 of 2003

The NHA seeks to 'regulate national health and to provide uniformity in respect of health services in South Africa; while protecting, promoting and fulfilling the rights of vulnerable groups such as women with disabilities'.³⁴⁹ The NHA provides that the needs of women with disabilities be considered when conditions for eligibility for free health services are being contemplated.³⁵⁰ Further subject to 'any condition prescribed by the Minister, pregnant and lactating women who are not members or beneficiaries of medical aid schemes must be provided with free health services as well as free termination of pregnancy services'.³⁵¹ The Minister, 'after consultation with the National Health Council is to make regulations concerning rehabilitation'.³⁵² The responsibility for providing health services therefore rests with the Minister of health who must ensure within the limits of available resources that essential health services which include primary health care services are provided to the

³⁴² Sec 52(1).

³⁴³ Sec 52(2).

³⁴⁴ Sec 52(3)(b).

³⁴⁵ Sec 18.

³⁴⁶ Sec 20.

³⁴⁷ Sec 19

³⁴⁸ Sec 21.

³⁴⁹ Sec 2(iv).

³⁵⁰ Sec 4(2)(d).

³⁵¹ Sec 4(3)(a)(c).

³⁵² Sec 90(1)(1).

population as may be prescribed after consultation with the National Health Council.³⁵³ When it comes to the rights of users, the health care provider must make all necessary information regarding the user's health status available to the user except where it would not be in the user's best interest.³⁵⁴

Primary mental health care (PMHC)

This is modelled by 'mental health in primary care'.³⁵⁵ PMHC is marked by integrating mental health care with 'primary level general health care services with staffing by general health practitioners as part of their routine function'.³⁵⁶

On the other hand mental health services may be 'offered as part of other health programmes operating at primary care level, such as services for maternal and child health, TB, HIV or chronic diseases'.³⁵⁷ The generalist staffs in this case are given 'training and supervision in mental health from mental health professionals'.³⁵⁸

The type of care usually provided at this level 'includes identification, assessment and treatment of common mental impairments'.³⁵⁹ In South Africa PMHC is provided at community, primary health care, community health care and at district hospitals.³⁶⁰ Generalists are to provide 'appropriate referral and short-term inpatient care for a period of 72 hours'.³⁶¹ Within the primary health care clinics, at 'least one psychotropic medicine for each psychiatric therapeutic category on the essential drug list' is provided.³⁶²

Secondary level of mental health care

This is provided at regional hospitals where there is a psychiatric unit.³⁶³ At the secondary level, care provided includes, 'inpatient and outpatient care as well as provision of support and outreach to all clinics and district hospitals in that region'.³⁶⁴

Tertiary level of mental health care

This is provided at specific psychiatric hospitals which provide 'specialised services such as forensic psychiatry, child and adolescent psychiatry, addiction treatment and psychogeriatrics'.³⁶⁵

³⁵³ Sec 3(d).

³⁵⁴ Sec 6(a).

³⁵⁵ Lazarus R & Freeman M (2009) 'Primary-level mental health care for common mental disorder in resource-poor settings: Models & practice- a literature review' pg 10.

³⁵⁶ Lazarus & Freeman (n 355 above) 10.

³⁵⁷ As above.

³⁵⁸ As above.

³⁵⁹ Lazarus & Freeman (n 355 above) 11.

³⁶⁰ Burns KJ 'Implementation of the Mental Health Care Act (2002) at district hospitals in South Africa: Translating principles into practice (2008) 98 *South African Medical Journal* 47.

³⁶¹ As above.

³⁶² Petersen I et al 'A task shifting approach to primary mental health care for adults in South Africa: Human resource requirements and costs for rural settings (2012)27 *Health Policy and Planning* 43.

³⁶³ Burns (n 355 above) 47.

³⁶⁴ As above.

³⁶⁵ As above.

Promotion of Equality and Prevention of unfair discrimination Act 4 of 2000

The Act prohibits unfair discrimination on the grounds of gender. Thus ‘no one may unfairly discriminate against any person on the grounds of gender including limiting women’s access to social services or benefits such as health’.³⁶⁶ The Act also prohibits discrimination on the ground of disability. It provides that ‘no person may unfairly discriminate against any person on the grounds of disability, including failing to eliminate obstacles that unfairly limit or restrict persons with disabilities from enjoying equal opportunities or failing to take steps to reasonably accommodate the needs of such people’.³⁶⁷ Therefore the Act protects women with psycho-social disabilities against unfair discrimination based on gender and discrimination arising as a result of a lack of access to mental health services; and established equality courts to enforce the provisions of the Act.³⁶⁸

3.4 Conclusion

This chapter examined the history of mental health care from the enactment of the Mental Health Act of 1973 to the passing of the current Mental Health Act of 2002. Before the enactment of the Mental Health Act of 2002, mental health care was informed by notions of the medical model which focused on treatment and institutionalised care. The Mental Health Care Act of 2002 which has the influences of the human rights and social model focuses on care, treatment and rehabilitation. A number of policies have been put in place to provide access to mental health care such as the Primary Mental Health Care and the Policy on Disability.

³⁶⁶ Sec 8(g).

³⁶⁷ Sec 9(c).

³⁶⁸ Sec 16.

Chapter four: Analysis of legal implementation

4.1 Introduction

The focus of this chapter is to provide an analysis of the implementation of the legal framework guaranteeing the rights of women with psycho-social disabilities to access mental health care in South Africa in light of the United Nations Convention on the Rights of Persons with Disabilities (CRPD). In this regard the Mental Health Act 17 of 2002 in providing such access is examined. The chapter also considers the implementation of the country's policies in ensuring access to mental health care by women with psycho-social disabilities and some of the barriers to implementation are also discussed.

4.2 Legal and Policy Framework

As discussed in Chapter three above, the right to access health care services is guaranteed in the 1996 Constitution. The Mental Health Care Act (MCHA) introduced in 2002, prior to the adoption of the CRPD focuses on providing the appropriate 'care, treatment and rehabilitation' to mental health care users. The section below aims to establish whether relevant sections of the MCHA comply with the standards set by the CRPD.

4.2.1 Access to mental health care

The MCHA seeks to regulate access to mental health care for different categories of persons namely voluntary and involuntary mental health care users; state patients and mentally ill prisoners.³⁶⁹

Voluntary and assisted mental health care

The CRPD directs State Parties to 'require health professionals to provide care to persons with disabilities on the basis of free and informed consent';³⁷⁰ which 'is or requires an exercise of one's legal capacity'.³⁷¹ The right to be free from non-consensual medical treatment is one of the freedoms included in the right to the highest attainable standard of health.³⁷² Therefore the 'right to free and informed consent is not merely a function of domestic laws, but is one of the human rights and freedoms guaranteed to all persons, and that must be applied without discrimination based on disability'.³⁷³ This makes any psychiatric practices or interventions imposed without free and informed consent unlawful in the context of the CRPD specifically and under international human rights law generally.³⁷⁴

The MCHA provides for voluntary care, treatment or rehabilitation a mental health care services based on the consent of the mental health care user.³⁷⁵ However under assisted mental health care, a mental health care user may be provided with treatment without her

³⁶⁹ Sec 3(b)(i).

³⁷⁰ Article 25(d).

³⁷¹ Minkowitz (n 171 as above); Article 12(2) directs states to recognize the legal capacity of persons with disabilities on an equal basis with others in all aspects of life.

³⁷² UN Committee on Economic, Social and Cultural Rights (11 August 2000)E/C.12/2000/4, General Comment 14 para 8, available at <http://www.unhcr.org/refworld/docid/4538838d0.html> (accessed 25 October 2012).

³⁷³ Minkowitz (n 171 above) 406.

³⁷⁴ As above.

³⁷⁵ Sec 25(1).

consent.³⁷⁶ Assisted mental health care occurs when an application is made on behalf of a person with a mental disability to the head of a health establishment for treatment.³⁷⁷ During the time of the application, it must be established that person on whose behalf the application is being made is suffering from a mental illness or severe or profound mental disability; requires the treatment or that the treatment is necessary for the health or safety of others; and that she is incapable of making an informed decision on the need for treatment.³⁷⁸ This provision does not accord with the CRPD which recognises the rights of persons with disabilities to enjoy legal capacity and to the support required in doing so.³⁷⁹

Involuntary mental health care

Section 33 of the MCHA on involuntary treatment as discussed under chapter three of this research contravenes Article 25 of the CRPD as it permits the provision of mental health care without the consent of the recipient. It is also contrary to Article 17 of the CRPD which guarantees the right to respect for the physical and mental integrity of persons with disabilities on an equal basis with others.³⁸⁰ As a procedural measure the MCHA directs the head of an establishment who receives an application for involuntary treatment to cause an examination to be done by two health practitioners.³⁸¹ This ensures that the application process is not done arbitrarily or abused by persons who seek to make it. Further after an examination had established the need for involuntary treatment, the head of the establishment is to admit the woman with a psycho-social disability for a 72-hour assessment to ascertain whether further involuntary treatment is necessary; while care, treatment and rehabilitation is being provided.³⁸² Though the 72-hour assessment serves as safeguard against institutionalisation, it is an additional violation of Article 17 of the CRPD.

Police intervention

Article 14 of the CRPD guarantees the right to liberty and security of person of persons with disabilities.³⁸³ In this regard, persons with disabilities 'are not to be deprived of their liberty unlawfully or arbitrarily; any deprivation of liberty must be in conformity with the law and the existence of a disability shall in no case justify a deprivation of liberty'.³⁸⁴ Similarly the 1996 Constitution of South Africa prohibits arbitrary deprivation of an individual's freedom.³⁸⁵

The powers given to the police to make arrests by the MCHA of any person they believe through personal observation or information obtained from a mental health practitioner that due to his or her mental illness is likely to inflict serious harm to him or herself or to others³⁸⁶

³⁷⁶ Sec 26.

³⁷⁷ Sec 26&27.

³⁷⁸ Sec 26(b)(i)(ii).

³⁷⁹ Article 12(3).

³⁸⁰ Article 17.

³⁸¹ Sec 33(4).

³⁸² Sec 34(1)(b).

³⁸³ Article 14(1)(b).

³⁸⁴ Article 14(1)(a)(b). This section has been discussed in chapter three under the MHCA.

³⁸⁵ Sec 12(1)(a).

³⁸⁶ Sec 40(1).

contravenes Article 14 of the CRPD. An arrest by the police in grounds of mental disability which deprives the individual of her liberty is not in conformity with the CRPD as the arrest is justified by the subjective belief that the one being arrested is a person with a mental disability. It also violates the right to the respect for the physical and mental integrity of the detainee who is likely to be committed to involuntary treatment after the arrest.

State Patients

The detention of accused persons believed to lack the capacity to understand court proceedings in a psychiatric hospital, violates the right to the respect for the physical and mental integrity of such persons as they are subjected to involuntary treatment based on an order from the court.³⁸⁷

Mental Health Review Boards (MHRBs)

The MHCA provides for the establishment of Mental Health Review Boards (MHRBs).³⁸⁸ The responsibility for the establishment of these boards falls on the provincial departments of health.³⁸⁹ The MHRBs which are 'quasi-judicial authorities'³⁹⁰ consider appeals; make decisions with regard to assisted or involuntary mental health care users; and consider periodic reports on the mental health status of mentally ill prisoners.³⁹¹ Although MHRBs have been established in 'most regions, their efficiency and effectiveness vary considerably'.³⁹² For instance a recent review conducted in the 'KwaZulu-Natal Province revealed that the MHRB had only visited seven out of the 36 hospitals in the region, six months before the review and ten of the hospitals had either never received a visit or had not been visited for more than two years'.³⁹³ The review concluded that the 'differences in operational efficiency of the various MHRBs have the potential of limiting the ability of the MHRB to intervene on time in the event of a violation of the Act'.³⁹⁴

4.3 Implementation of Legal framework

The implementation of the laws and policies would be analysed based on their accessibility, availability and affordability and quality as required by international human rights law.³⁹⁵

4.3.1 Physical accessibility

The CRPD recommends that health services as well as habilitation and rehabilitation services be provided as close as possible to people's own communities, including rural areas.³⁹⁶ In light of that, the MHCA seek to ensure the provision of mental health care, treatment and rehabilitation services at primary, secondary and tertiary levels of health care;

³⁸⁷ Art17.

³⁸⁸ Secs 18-24.

³⁸⁹ Sec 18(1).

³⁹⁰ S Ramlall et al 'Impact of the South African Mental Health Care Act No. 17 of 2002 on regional and district hospitals designated for mental health care in KwaZulu-NNatal' (2010)100 *South African Medical Journal* 667.

³⁹¹ Sec 18(1)

³⁹² Burns (n 360 above) 105.

³⁹³ As above.

³⁹⁴ As above.

³⁹⁵ General Comment No 14 para 12.

³⁹⁶ Arts 25(c) & 26(b).

whiles promoting the provision of community –based rehabilitation services.³⁹⁷ The importance of integrating mental health into primary health care has been endorsed by most provincial services with some training initiatives taken for primary health care nurses.³⁹⁸ Through the primary health care system, mental health care is provided through local clinics which serve as the first point of service for communities with referrals done to hospitals.³⁹⁹ Psychotropic medicines are accessible at the primary health care level.⁴⁰⁰ With regards to psychotropic medicines, primary health care nurses are either allowed to continue prescription or to prescribe in emergencies only whiles ‘primary health care doctors are allowed to prescribe all medications on the essential drugs list’.⁴⁰¹

Mental health care has been integrated into maternal health services at the primary care level in some provinces. For example, the ‘Perinatal Mental Health Project (PMHP) based at the Mowbray Hospital in the Western Cape Province has been able to develop a ‘stepped care’ intervention for maternal mental health that is integrated into antenatal care’.⁴⁰² Thus the women are screened for maternal mood disorders during their antenatal visits; such that from July 2008 to end of June 2011, 90% of 6 3747 women had been screened.⁴⁰³ A woman who screens positive is seen by an on-site counsellor and an on-site psychiatrist where there is need for specialist care.⁴⁰⁴

However physical accessibility remains a challenge due to high transportation costs.⁴⁰⁵ In the case of women, it means that extra costs such as child care and loss of income to access mental health care services located out of their reach will be incurred. This is mainly attributable to the scarcity of public transport to persons with disabilities coupled with a taxi industry generally known for their ‘unsafe modes of travel’.⁴⁰⁶ Access to emergency transport in the form of ambulance service is a major challenge in the rural areas to the poor making access to emergency care impossible.⁴⁰⁷

4.3.2 Economic accessibility

States have a duty under the CRPD to provide persons with disabilities with the ‘same range, quality and affordable health programmes as provided to other persons, including in the area of sexual and reproductive health and population-based public health programmes’.⁴⁰⁸ In South Africa, all health services at the primary health care level including women’s

³⁹⁷ Sec 4(a)(b).

³⁹⁸ WHO (n 73 above) 15.

³⁹⁹ WHO (n 73 above) 17.

⁴⁰⁰ As above.

⁴⁰¹ As above..

⁴⁰² S Honikam et al ‘Stepped care for maternal mental health: a case study of the Perinatal Mental Health Project in South Africa’ (2012) 9 *PloS Medicine* 1.

⁴⁰³ Honikam et al (n 402 above) 2.

⁴⁰⁴ As above.

⁴⁰⁵ South African Human Rights Commission (SAHRC) ‘Public inquiry: access to health care services’(2009) 42, available at <http://www.info.gov.za/view/DownloadFileAction?id=99769> (accessed 26 October 2012).

⁴⁰⁶ Department of Women, Children and People with Disabilities (DWCP) ‘Country report on the implementation of the UNCRPD’(2011)First report to the UN, unofficial draft version, 27. (Copy on file with author).

⁴⁰⁷ SAHRC (n 405 above) 42.

⁴⁰⁸ Art 25(a).

reproductive health services such as family planning care, are free.⁴⁰⁹ Rehabilitation services are free if provided at a home or within the community.⁴¹⁰ Persons with disabilities who meet certain 'nationally determined criteria are able to access free health care and rehabilitation at a hospital level in the public sector'.⁴¹¹ In spite of the fact that primary health care for women with disabilities is free, an inquiry conducted by the South African Human Rights Commission (SAHRC) established that 'only half of the of those who visited a public hospital obtained services for free even though they were eligible. This also affected access to mental health care'.⁴¹²

4.3.3 Information accessibility

The department of health oversees public education and awareness campaigns on mental health and mental disorders.⁴¹³ This is done in partnership with NGOs and other professional, consumer and advocacy bodies.⁴¹⁴ For past 5 years, government agencies have collaborated with NGOs in public education promotion in all the provinces.⁴¹⁵ Issues around women's mental health have remained the focus of some of these educational campaigns.⁴¹⁶ Women's mental health needs still not received the needed attention due to 'insufficient prioritisation of government resources to mental-health related programmes'.⁴¹⁷

4.3.4 Quality and Acceptability

The Department of health adopted a national drug policy committed to the use of an essential medicines list.⁴¹⁸ The Department also prepared and developed the Standard Treatment Guidelines and Essential Drug List which ensures access to medicines that are of good acceptable quality.⁴¹⁹ However in the absence of national medical insurance women with psycho-social disabilities who do not engage in any form of employment due to their disability, would not be able to afford the necessary medicines which are not provided at the primary level of care. Moreover with the integration of mental health into primary health care, health workers as well as general practitioners must be trained to be sensitive to the needs of women with disabilities who access primary health care.

4.3.5 Availability

Currently there are 3 460 outpatient mental health facilities in the country which treat 1660 users per 100 000 of the general population.⁴²⁰ The percentage of female users is unknown.⁴²¹ With regards to day treatment facilities; the SA Federation of Mental Health that

⁴⁰⁹ WHO (n 73 above) 17.

⁴¹⁰ DWCP (n 406 above) 47.

⁴¹¹ As above.

⁴¹² DWCP (n 406 above) 41-42.

⁴¹³ WHO (n 73 above) 21.

⁴¹⁴ As above.

⁴¹⁵ As above.

⁴¹⁶ As above.

⁴¹⁷ A Moultrie & S Kleintjies 'Women's mental health in South Africa' (2006) 360.

⁴¹⁸ O Jack-Ide et al (n 75 above) 51.

⁴¹⁹ Jack-Ide et al (n 75 above) 53.

⁴²⁰ WHO (n 73 above) 11.

⁴²¹ As above.

41% are female users.⁴²² The department of health does not keep statistics regarding gender and age in the use of mental health facilities.⁴²³ The Department has developed standardised treatment protocols in line with the Standard Treatment Guidelines and Essential Drugs List which make medicines needed to manage common psychiatric disorders available at both the district and community levels.⁴²⁴ The Provincial governments ensure that psychotropic medicines are available and distributed to all levels of health of care.⁴²⁵ However the availability of health care in rural and urban area vary for instance the Perinatal Mental Health Projects which seeks to integrate mental health care into maternal care are all based in urban areas. This implies that the mental health needs of women who go for pre-natal and post-natal care would be overlooked.

4.4 Barriers to implementation

Governmental departments such as the National Health Department and the Department of Women, Children and Persons with Disabilities seek to promote policies that implement the right to mental health care of women with psycho-social disabilities. In addition to the resource and budgetary constraints, various barriers to accessing mental health care exist.⁴²⁶ These include, out dated psychiatric hospitals which are often unfit for human use; lack of monitoring and research; and undeveloped community mental health and psycho-social rehabilitation services.⁴²⁷

4.4.1 Financing of mental health services

Currently there is no specific budget for mental health either at the national or provincial level. This implies that 'mental health services are funded out of general health budgets where they inevitably end up at the bottom of a pile of pressing needs when money is allocated'.⁴²⁸ It was reported in a recent survey that only 3 (Northern Cape, Mpumalanga and North West) out of the nine provinces could report on their mental health expenditure.⁴²⁹ These reported 1%, 8% and 5% respectively as their mental health expenditure; reflecting the low allocation made to mental health despite the high prevalence of mental disorders.⁴³⁰

In the KwaZulu-Natal Province, research conducted established that from 2005 to 2010 'budget increases to six psychiatric hospitals ranged from 8% to 25% with a mean 5-year increase of 19% and a mean annual increase of 3.8%'.⁴³¹ This was in stark contrast 'with the budget increases to seven general hospitals over the same 5-year period, which a 'range of 29% to 64%; a mean 5-year increase of 51% and a mean annual increase of 10.2%'.⁴³²

⁴²² As above.

⁴²³ As above.

⁴²⁴ Jack-Ide et al (n 75 above) 53.

⁴²⁵ As above.

⁴²⁶ JK Burns 'The mental health gap in South Africa-a human rights issue' (2011)6 *Equal Rights Review* 104.

⁴²⁷ As above.

⁴²⁸ As above.

⁴²⁹ WHO (n 395 above) 9.

⁴³⁰ Burns (n 426 above) 104.

⁴³¹ As above.

⁴³² As above.

These percentages reveal the 'gross inequity in the allocation of provincial health budgets to psychiatric facilities'.⁴³³ The failure to consider the needs of mental health care in budget allocation affects the provision and ultimately the accessibility of mental health care.

4.4.2 Human resources

The availability of human resource has a significant impact on the accessibility of mental health care and human resources for mental health care in South Africa is highly inadequate.⁴³⁴ The mental health facilities of the Department of Health or NGOs constitute about 9.3 per 100 000 of the population.⁴³⁵ This number is made up of 0.28 psychiatrists, 0.45 medical doctors, 7.45 nurses, 0.32 psychologists, 0.4 social workers, 0.13 occupational therapists and 0.28 other health or mental health workers.⁴³⁶ These numbers imply that as far 'as psychiatrists are concerned, South Africa has less than 30% of the number required to comply with national of 1 per 100 000 population'.⁴³⁷ Moreover the concentration of mental health professionals in urban centres makes mental health care services inaccessible to large rural areas.⁴³⁸ For instance in KwaZulu-Natal Province out of the 32 psychiatrists working in the public health sector, only 6 are located outside of the major cities.⁴³⁹

4.4.3 Monitoring and research

Research and collection plays an important role by informing the development of evidence-based interventions for mental health care delivery. However 4 out of the 9 provinces do not 'formerly defined a minimum data set of items to be collected by mental health facilities'.⁴⁴⁰ The rest of the provinces have a 'formally defined list of individual data items that ought to be collected by all mental health facilities'.⁴⁴¹ In a country where only five percent of research published in the past five years has been on mental health care⁴⁴²; it would be very difficult to access the actual impact of the MHCA and policy implementation. There is a need for research which is focused on women's mental health needs and how these needs are being met at the policy implementation level.

4.4.4 Community mental health and psycho-social rehabilitation services

The provision of community mental health and psycho-social rehabilitation services is poor. This is due to the fact that they are only 80 day treatment facilities available in the country for a population of about 47 million.⁴⁴³ Therefore these facilities treat 3.4 users per 100 000 of the general population.⁴⁴⁴ Female users of the day treatment facilities constitute 41%.⁴⁴⁵

⁴³³ As above.

⁴³⁴ Burns (n 426 above) 105.

⁴³⁵ WHO (n 73 above) 17.

⁴³⁶ As above.

⁴³⁷ Burns (n 426 above) 105.

⁴³⁸ Burns (n 426 above) 106.

⁴³⁹ As above.

⁴⁴⁰ Jack-Ide et al (n 75 above) 55.

⁴⁴¹ WHO (n 73 above) 23.

⁴⁴² WHO (n 73 above) 26.

⁴⁴³ Burns (n 426 above) 105.

⁴⁴⁴ WHO (n 73 above) 11.

⁴⁴⁵ As above.

With regards to community based inpatient units which are 41 in number; psycho-social interventions are available in some provinces.⁴⁴⁶ In two of the provinces 1-20% of users received psycho-social interventions while in other 80-100%.⁴⁴⁷ This implies that the decentralisation of mental health care as envisaged by the MHCA has not been effectively implemented.

4.5 Conclusion

This chapter analysed the legal and institutional framework guaranteeing the right to access mental health care by women with psycho-social disabilities. This was done by reviewing some of the provisions of the Mental Health Care Act (MHCA) of 2002 in light of the UN Convention on the Rights of Persons with Disabilities (CRPD) which provides for the right to health care based on consent and in a manner that respects the human rights of the person. The MCHA though it seek to protect the fundamental human rights of persons with mental disabilities, its provisions on assisted care and involuntary treatment which permits a person to be given care, treatment and rehabilitation without her consent contravenes the CRPD. The inefficiencies of the institutions in guaranteeing access to mental health care can be attributed to budgetary constraints; lack of human resources; lack of monitoring and research; and inadequate community health and psycho-social services.

⁴⁴⁶ WHO (n 73 above) 11.

⁴⁴⁷ As above.

Chapter Five: Conclusion and Recommendations

5.1 Conclusions

This research study sought to establish how the legal framework of South Africa guarantees the right to access mental health care by women with psycho-social disabilities.⁴⁴⁸ It then examined the extent to which the right to access mental health care is guaranteed by the Mental Health Care Act (MHCA) 17 of 2002 in light of the Convention on the Rights of Persons with Disabilities (CRPD).⁴⁴⁹

International human rights law guarantees the right to physical and mental health which includes the right access health care services. The CRPD together with all the other instruments mentioned in this study create awareness of the discrimination and inequalities faced by persons with disabilities especially women with disabilities. The adoption of the CRPD particularly saw the birth of the first international disability-specific treaty which seeks to guarantee the rights of persons with disabilities including women with psycho-social disabilities.

In relation to the right to health, the Convention provides for the rights of women with psycho-social disabilities to the mental health care they require including rehabilitation and habilitation. Women with psycho-social disabilities therefore have the right to sexual and reproductive health services as well as social services such as housing and medical insurance. In addition to being commensurate with the needs of women with psycho-social disabilities; mental health care must be physically accessible; economically affordable and mental health information must be accessible. Certain obligations relating to mental health care are immediately implementable and others are subject to progressive realisation.

The African regional human rights system spearheaded by the African Charter provides for the right to physical and mental health as well as the rights of persons with disabilities to special measures. The African Commission in *Purohit v The Gambia* opined that persons with mental disabilities should not be denied proper care. The African Women's Protocol recognises the right of women with disabilities to specific measures commensurate with their physical, economic and social needs. The SADC Protocol on Gender and Development on the other hand, does not provide a human rights perspective as regards persons with disabilities. It seeks to protect persons with disabilities based on their vulnerabilities. This resonates with the medical model of disability which focuses on the impairment and not on the rights of the person with a disability arising from the impairment.

Mental health care in South Africa form the mid-19th century through the era of Apartheid was based on institutionalised care and was marked by human rights abuses. The adoption of the Mental Health Act 17 of 1973 which was instigated by fear of persons with mental disabilities; perpetuated mental health care based on institutionalisation focused on control

⁴⁴⁸ Chapter 3 on legal and policy framework in South Africa 27.

⁴⁴⁹ Chapter 4 on analysis of legal implementation 40.

and treatment. The dawn of democracy and the adoption of the 1996 Constitution led to a shift in health care delivery generally and mental health care specifically. The Constitution guarantees the right to access health care services albeit within the available resources of the state.

In 1997, the government in collaboration with various civil society organisations produced the Integrated National Disability Strategy which sought to overhaul the health system by decentralising health care to meet the needs of persons with disabilities. The White Paper for the transformation of the health system further sought to integrate mental health care services into primary health care.

In 2002 Mental Health Care Act (MHCA) No 17 was enacted to provide care, treatment and rehabilitation to persons with mental illness. It provides human rights guarantees thorough safeguards such as the MHRBs. However MHCA's provisions on assisted and involuntary mental health contravenes international human rights law to the extent that they allow treatment to be administered without consent; limit the individual's right to liberty and security; and the right to exercise legal capacity as guaranteed the CRPD.

Despite the guarantees of mental health care in the constitutional and legislative framework, the implementation of the MHCA has been fraught with challenges. These include inadequate mental health human resources; poor financing of mental health services; poor research and information systems to monitor mental health service delivery; and poor infrastructure. These challenges have limited the accessibility, availability, quality, affordability and acceptability of mental health care. The ineffective implementation of the MHCA has a disproportionate impact on women with mental disabilities who by reason of childbearing, discrimination, sexual violence and HIV experience more mental health problems than men.

5.2 Recommendations

The following recommendations can be proffered by the researcher candidate in order to address the challenges identified.

- a. A mental health policy must be developed to provide direction to the implementation of the MHCA. Such a policy must address the specific needs of women with psychosocial disabilities and how to make mental health care generally more accessible.
- b. Research and data collection must be improved in order to effectively monitor mental health service delivery. Disaggregated data on mental health care users especially women must be produced to help in the creation of mental health care services that would best serve their needs. This would be in fulfilment of the obligation of states under the CRPD to collect statistical and research data which would inform policy formulation and its implementation.⁴⁵⁰

⁴⁵⁰ Art 31.

- c. More resources would have to be committed to the provision of mental health care at the primary care level. Training and evaluation programmes would have to be conducted for the general staff at the primary health care level. General staff need to be trained to appreciate the mental health care needs of women with psycho-social disabilities. In addition specialist mental health personnel would have to be trained to provide support at the primary health care level.
- d. Community mental health services need to be well developed to provide accessible mental health care services to women in rural areas.

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Bibliography

Legislation

Constitution of South Africa Act 108 of 1996.

Mental Health Care Act 17 of 2002.

National Health Act 61 of 2003.

Books

Arnardottir, OM & Quinn, G (2009) *The UN Convention on the Rights of Persons with Disabilities: European and Scandinavian perspectives* Leiden –Boston: Martinus Nijhoff Publishers.

Heyns, CH & Killander, M (ed) (2010) *Compendium of key human rights documents of the African Union* Pretoria: Pretoria University Law Press.

Ssenyonjo, M (2011) *The African regional human rights system* Leiden-Boston: Martinus Nijhoff Publishers.

Steiner, H et al (2007) *International human rights in context: Law, politics and morals* Oxford: Oxford University Press.

Chapters in books

Barnes, C 'The social model of disability: A sociological phenomenon ignored by Sociologists?' in T Shakespeare(ed) (1998) *Disability reader: Social science perspectives*: Continuum International Publishing.

Biegon, J 'The promotion and protection of disability rights in the African human rights system' in Grobbelaar, I & Van Reen, T (eds) *Aspects of disability law in Africa*: Pretoria University Law Press.

Rispel, L & Goosen, M 'Women and the health care system' in Goosen, M et al (eds) (1996) *The South African women's health book* Cape Town: Oxford University Press.

Tromel, S 'A personal perspective on the drafting history of the United Nations Convention on the Rights of Persons with Disabilities' in G Quinn & L Waddington *European Yearbook of Disability Law* (2009)120-132.

Journal articles

Behrendt A & Moritz S 'Posttraumatic stress disorder and memory problems after female genital mutilation' (2005)162 *The American Journal of Psychiatry* 1000-1002.

Burns, JK 'The mental health gap in South Africa-a human rights issue' (2011) 6 *Equal Rights Review* 99-113.

Burns, JK 'Mental Health services funding and development in Kwazulu-Natal: a tale of inequity and neglect' (2010)100 *South African Medical Journal* 662-666.

Davies, G et al 'Mental health challenges in HIV positive women, adolescents and children' (2002) 11 *The Source* 1-5.

Degener, T 'Disabled women and international human rights' (2001)3 *Women and International Human Rights Law* 267-282.

Doyal, L & Hoffman, M 'The growing burden of chronic diseases among South African women' (2009)27 *Continuing Medical Education* 458.

Natalie, D et al 'Human rights violations of people with mental and psychosocial disabilities: an unresolved global crisis' (2011) 378 *The Lancet* 1664-1675.

Edwige, F et al 'An assessment of mental health policy in Ghana, South Africa, Uganda and Zambia' (2011) 9 *Health Research Policy and Systems* 17.

Gostin, LO & Gable, L 'The human rights of persons with mental disabilities: A global perspective on the application of human rights principles to mental health' (2004)63 *Maryland Law Review* 20-121.

Gostin, LO 'Human Rights of Persons with Mental Disabilities: The European Convention of Human Rights' (2000) 23 *International Journal of Law and Psychiatry* 125-159.

Hendricks, A 'UN Convention on the Rights of Persons with Disabilities' (2007)14 *European Journal of Health Law* 276.

Heyns, C 'African Regional Human Rights System: The African Charter' (2004)108 *Penn State Law Review* 682.

Hughes, B & Paterson, K 'The social model of disability and the disappearing body: Towards a sociology of impairment, disability & society (1997)12 *Disability and Society* 325-34.

Hunt, P & Mesquita, J 'Mental disabilities and the right to the highest attainable standard of health'(2006)28 *Human Rights Quarterly* 332-356.

Jack-Ide, O et al 'A comparative study of mental health services in two African countries: South Africa and Nigeria'(2012)4 *International Journal of Nursing and Midwifery* 50-57.

Kanter, AS 'The promise and challenge of the United Nations Convention on the Rights of Persons with Disabilities'(2007)34 *Syracuse Journal of International Law and Commerce* 287.

MacKay, D 'The United Nations Convention on the Rights of Persons with Disabilities'(2006-2007)34 *Syracuse Journal of International Law and Commerce* 328.

Minkowitz, T 'United Nations Convention on the Rights of Persons with Disabilities and the right to be free from non-consensual psychiatric interventions' (2007) 34 *Syracuse Journal of International Law & Commerce* 407.

Ngwena, CG 'Protocol to the African Charter on the Rights of Women: implications for access to abortion at the regional level' (2010) 110 *International Journal of Gynaecology and Obstetrics* 164.

Ofori-Atta, A et al 'Common understandings of women's mental illness in Ghana: results from a qualitative study' (2010) 22 *International Review of Psychiatry* 589-598.

Patel, V et al 'Women, poverty and common mental disorders in four restricting societies' (1999) 49 *Social Science & Medicine* 1461-1471.

Perlin, ML 'A change must come: The implications of the United Nations Convention on the Rights of Persons with Disabilities for the domestic practice of constitutional mental disability law' (2009) 29 *Northern Illinois University Law Review* 490.

Prince, M et al 'No health without Mental Health' (2007) 370 *The Lancet* 859-77.

Quinlivan, S 'The United Nations Convention on the Rights of Persons with Disabilities: An introduction' (2012) 13 *ERA Forum* 74.

Ramlall, S et al 'Impact of the South African Mental Health Care Act No. 17 of 2002 on regional and district hospitals designated for mental health care in KwaZulu-Natal' (2010) 100 *South African Medical Journal* 667-670.

Rensburg, JV 'A framework for current public mental health care practice in South Africa' (2007) 10 *African Journal of Psychiatry* 205-209.

Saxena, S et al 'Resources for mental health: scarcity, inequity and inefficiency' (2007)370 *The Lancet* 878-89.

Seedat S et al 'Mental health service use among South Africans for mood, anxiety and substance use disorders'(2009) 99 *South African Medical Journal* 346-352.

Stein, MA & Lord, JE 'Monitoring the Convention on the Rights of Persons with Disabilities: Innovations, lost opportunities, and future potential' (2010) 32 *Human Rights Quarterly* 690.

Thornicroft, G et al 'Discrimination in health care against people with mental illness' (2007) 19 *International Review of Psychiatry* 113-122.

International treaties

African Charter on Human and Peoples' Rights (27 June 1981) CAB/LEG/67/3 rev. 5, 21 I.L.M. 58 (1982).

African Charter on the Rights and Welfare of the Child (11 July 1990) CAB/LEG/24.9/49 (1990).

Convention on the Elimination of All Forms of Discrimination Against Women, 18 December 1979, United Nations, Treaty Series, vol. 1249, p.13.

International Convention on the Elimination of All Forms of Racial Discrimination (21 December 1965) United Nations, Treaty Series, vol. 660, p.195.

International Covenant on Economic, Social and Cultural Rights (16 December 1966) United Nations, Treaty Series, vol 993 p 3.

Protocol to the African Charter on Human and Peoples' Rights on the Rights of the Women in Africa (2003/2005).

Protocol to the African Charter on Human and Peoples' Rights on the Rights of the Women in Africa (2003/2005).

SADC Protocol on Health

UN Convention on the Rights of Persons with Disabilities (13 December 2006) A/RES/61/106, Annex 1.

UN Convention on the Rights of Persons with Disabilities (13 December 2006) A/RES/61/106, Annex 1.

United Nations Charter (24 October 1945) 1 UNTS XVI.

Universal Declaration of Human Rights (10 December 1948) 217 A (III).

General comments, recommendations and resolutions

Declaration on the Rights of Disabled Persons (1975) General Assembly resolution 3447(XXX).

Declaration on the Rights of Mentally Retarded Persons (1971) General Assembly resolution 2856 (XXVI).

Principles for the protection of persons with mental illness and the improvement of mental health care (1991) General Assembly resolution 46/119.

Standard Rules on the Equalization of Opportunities for Persons with Disabilities (1993) General Assembly resolution 48/96.

UN Committee on Economic, Social and Cultural Rights (11 August 2000) E/C.12/2000/4, General comment 14.

UN Committee on Economic, Social and Cultural Rights (9 December 1994) E/1995/22, General Comment number 5.

UN Committee on Economic, Social and Cultural Rights (11 August 2000) E/C.12/2000/4, General Comment 14.

UN Committee on the Elimination of Discrimination Against Women (1999) A/54/38/Rev1, chap 1, General Recommendation no 24.

World Programme of Action concerning Disabled Persons (1982) General Assembly resolution 37/52.

Reports/papers

Background Paper prepared by the Division for Social Policy and Development of the United Nations Secretariat for the “Informal Consultative Meetings on International Norms and Standards for Persons with Disabilities.” (9 February 2001)

Bartlett, P & Hamzic, V ‘Reforming mental disability law in Africa: Practical tips and suggestions’ (2010) Human Rights Law Centre, University of Nottingham.

CBM ‘Community mental health policy’ (2008) Community Mental Health Advisory Working Group.

Department of Health ‘National health insurance in South Africa: Policy paper (2011) Republic of South Africa.

Department of Women, Children and People with Disabilities (DWCP) ‘Country report on the implementation of the UNCRPD’ (2011) First report to the UN, draft version.

Funk, M et al ‘Mental health and development: treating people with mental health conditions as a vulnerable group’ (2010) World Health Organization.

Gomel, MK 'Nations for mental health: a focus on women' (1997) World Health Organization.

Lazarus, R & Freeman, M 'Primary-level mental health care for common mental disorders for resource-poor settings: Models & practice- a literature review. Sexual violence research initiative' (2009) Medical Research Council, South Africa.

Moultrie, A & Kleintjres, S 'Women's mental health in South Africa' (2006).

National Mental Health Consumer & Carer Forum 'Unravelling psychosocial disability' (2011) Position statement by the National Mental Health Consumer & Career Forum on Psychosocial Disability Association with mental health conditions. Canberra: NMHCCF.

Quinn, R & Degner, T 'Human rights and Disability: The current use and future potential of United Nations human rights instruments in the context of disability' (2002).

Report of the Special Rapporteur to the Commission for Social Development 'Monitoring the implementation of the Standard Rules on the Equalization of Opportunities for Persons with Disabilities' (12-22 February 2002) E/CN.5/2002/4.

South African Human Rights Commission 'Public inquiry: access to health care services' (2009) South Africa.

UN Office of the High Commissioner for Human Rights, Fact Sheet No. 31: The Right to Health (2008) No. 31.

World Health Organization & Department of Psychiatry and Mental Health University of Cape Town 'WHO-AIMS report on mental health system in South Africa (2007) South Africa.

Case law

Free Legal Assistance Group and Others v Zaire (2000) AHRLR 74 (ACHPR 1995).

Minister of Health and Others v TAC and others 2002 10 BCLR 1033(CC).

Purohit and Another v The Gambia (2003) AHLR 96 (ACHPR).

Soobramoney v Minister of Health 1998 (1) SA 765 (CC).

Internet sources

Ratification Table: Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, available at <http://www.achpr.org/instruments/women-protocol/ratification/> (accessed 30 August 2012).

SADC Protocol on Gender and Development (2008), available at <http://www.sadc.int/english/key-documents/protocols/protocol-on-gender-and-development/> (accessed 9 October 2012).

SADC Protocol on Health (1998), available at http://www.iss.co.za/af/regorg/unity_to_union/pdfs/sadc/protocols/health.pdf

SADC Treaty (2009) as amended, available at <http://www.sadc.int/index/browse/page> (accessed 9 October 2012).

Status of ratification, available at http://www.bayefsky.com/pdf/cedaw_ratif_table.pdf (accessed 30 August 2012).

UN Office of the High Commissioner for Human Rights, Fact Sheet No. 31: The Right to Health (2008) No. 31, available at: <http://www.unhcr.org/refworld/docid/48625a742.html> accessed (18 May 2012).