The Moral Imperative to Prioritize Mental Health Care in Primary Health Care Services:

A Bioethical Analysis

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Declaration

I, **Reabetswe Dithung** (Student number: **708997**) am a postgraduate student registered for the Master of Science in Medicine (Msc.Med) in Bioethics & Health Law at the Steve Biko Centre for Bioethics at the University of the Witwatersrand (Wits), in Johannesburg, South Africa.

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Dedication

I dedicate this research to everyone who currently has or has had previous experience with mental illness or any mental health condition. The discrimination and stigma associated with mental illness has prevented many, including myself, from accessing the appropriate but necessary care.

I pray that you believe and trust in yourself more.

I pray that you become more gentle, kind, loving and understanding with yourself.

The mind can be a very scary place, but it can also be very beautiful.

Whenever the mind becomes too dark, always remember that:

> *"We suffer more in imagination than in reality*" – Seneca.

Abstract

Despite the emergence of bioethical and human rights protections, intergenerational injustices and violations in the mental health care context have exacerbated the vulnerability of mental health care users (MHCUs) and mentally ill patients. The relationship between mental health and socio-economic development largely coincides with the emergence of colonialism. South Africa's historical period reveals an important correlation between mental health and socio-economic development. Research has revealed that mental ill-health and poverty interact in a negative cycle. This relationship has had detrimental consequences on the right to access appropriate, available and quality mental health care. Given the historical propensity for using mental health as a tool of oppression, it is vital to interrogate and scrutinize mental health care laws, policies and practices in South Africa against the backdrop of its socio-cultural, socio-economic and socio-political contexts. Indigenous healing practices formed part of African culture and healthcare prior to the arrival of western medicine. An individual's capability to be healthy is limited when social, cultural, and economic injustices infringe upon a person's dignity and their freedoms are left unaddressed. Mental health care, therefore, ought to be prioritized in primary health care (PHC) services to improve South Africa's socio-economic development, on the basis of African thought, bioethics and human rights.

Keywords: Healing, Mental Health, Justice, Capability, Ubuntu, Dignity, Primary Health Care (PHC), African Traditional Medicine (ATM).

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In mastering myself, I had to overcome who I had to be to survive and become who I am to thrive.
I am so proud of you, Rabi.

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List of Abbreviations and Acronyms

AAAS	American Association for the Advancement of Science
ACHPR	African Commission on Human and Peoples' Rights
AfCHPR	African Court on Human and Peoples' Rights
AHPCSA	Allied Health Professions Council of South Africa
AIDS	Acquired Immunodeficiency Syndrome
AMA	American Medical Association
ANC	African National Congress
APA	American Psychiatric Association
ARV	Anti-Retroviral drugs
ATM	African Traditional Medicine
AU	African Union
AUABC	African Union Advisory Board on Corruption
AUCIL	African Union Commission on International Law
BMA	British Medical Association
CC	Constitution Court
CDC	Centre for Disease Control and Prevention
CESCR	Committee on Economic, Social and Cultural Rights
CIDI	Composite International Diagnostic Interview
CMS	Council for Medical Schemes
COVID-19	Coronavirus disease 2019
CRC	Convention on the Rights of the Child
CSIR	Council for Science and Industrial Research
CRPD	Convention on the Rights of Persons with Disabilities
CSO	Civil Society Organisation
CZL	Code of Zulu Law
DoH	Department of Health
DPI	Department of Public Information
DRC	Directorate of Radiation Control
DSM	Diagnostic and Statistical Manual of Mental Disorders
ECOSOC	Economic and Social Council
EMS	Emergency Medical Services
GBD	Global Burden of Disease
GBV	Gender-based Violence
GDoH	Gauteng Department of Health
GDP	Gross Domestic Product

GMHMP	Gauteng Mental Health Marathon Project
HCP	Health Care Practitioner
HIV	Human Immunodeficiency Virus
HPCSA	Health Professions Council of South Africa
ICC	International Criminal Court
ICCPR	International Covenant on Civil and Political Rights
ICD	International Statistical Classification of Diseases
ICESCR	International Covenant on Economic, Social and Cultural Rights
ICMH	International Congress of Mental Hygiene
LDA	Lunatics Detention Act
LE	Life Esidimeni
LGBTQI	Lesbian, gay, bisexual, transgender, queer and intersex
LIC	Lower-income countries
LMIC	Low-and middle-income countries
MASA	Medical Association of South Africa
MDG	Millennium Development Goals
MEC	Member of the Executive Council
MCC	Medicines Control Council
MHCA	Mental Health Care Act
MHCU	Mental Health Care User
MHPF	Mental Health Policy Framework and Strategic Plan
MNS	Mental, neurological and substance use
MoH	Ministry of Health
NCMH	National Committee of Mental Hygiene
NDoH	National Department of Health
NDP	National Drug Policy
NGO	Non-Governmental Organization
NHA	National Health Act
NHI	National Health Insurance
NHLS	National Health Laboratory Services
NRCATM	National Reference Centre for African Traditional Medicine
OAU	Organization of African Unity
OHCHR	Office of the United Nations High Commissioner for Human Rights
OHO	Office of the Health Ombud
PASA	Psychological Association of South Africa
PBC	Peace Building Commission
PDM	Psychodynamic Diagnostic Manual
PHAC	Public Health Agency of Canada
PHC	Primary Health Care
PLHIV	People living with HIV

PMB	Prescribed Minimum Benefits
PTSD	Posttraumatic Stress Disorder
REC	Research Ethics Committee
REC	Regional Economic Communities
SADAG	South African Depression and Anxiety Group
SADC	Southern African Development Community
SAFMH	South African Federation for Mental Health
SAHRC	South African Human Rights Commission
SAHPRA	South African Health Products Regulatory Authority
SAMA	South African Medical Association
SAMR	South African Medical Review
SANC	South African Council of Nursing
SASH	South African Stress and Health
SASOP	South African Society of Psychiatrists
SDGs	Sustainable Development Goals
SDH	Social Determinants of Health
SPSA	Society of Psychiatrists in South Africa
TB	Tuberculosis
THP	Traditional Health Practitioners
THPA	Traditional Health Practitioners Act
UCT	University of Cape Town
UDHR	Universal Declaration of Human Rights
UHC	Universal Health Coverage
UMIC	Upper-Middle-Income Country
UN	United Nations
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNHRC	United Nations Human Rights Council
UNSC	United Nations Security Council
UK	United Kingdom
USA	United States of America
VCLT	Vienna Convention on the Law of Treaties
WFMH	World Federation for Mental Health
WHO	World Health Organization
WHO-AIMS	World Health Organization's Assessment Instrument for Mental Health Systems
WHO's mhGAP	World Health Organization's Mental Health Gap Action
WHO Project Atlas	World Health Organization's Mental Health Atlas Project
Wits	University of the Witwatersrand
WMA	World Medical Association
WPA	World Psychiatric Association

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Chapter 1: Introduction

1.1. Background Literature Analysis and Critique

Mental health is an integral aspect of health with its origins in public health, clinical psychiatry, social psychology, and other disciplines of knowledge (Bertolote, 2008). Mental health was only taken seriously as a human rights concern from the mid-20th century as a result of revolutionary attempts during the inter-war period to overcome malignant social ills and public health concerns (Žalnora and Miežutavičiūtė, 2016). This chapter provides essential definitions, approaches, and contextualisations related to mental health and socio-economic development.

1.1.1. Evolving definitions in Mental Health

The World Health Organization (WHO) provides the following definition of mental health:

> "A state of well-being in which every individual realises his or her potential, can cope with the normal stresses of life, can work productively and fruitfully, and can contribute to his or her community" (World Health Organization (WHO), 2018; Kolappa, Henderson and Kishore, 2013).

This universally applied definition places emphasis on mental health as a critical component of health and, therefore, well-being. On the 10th of October 1992, World Mental Health Day was introduced as a global initiative by the World Federation for Mental Health (WFMH) to promote mental health advocacy, improve mental health literacy and contribute towards upscaling access to mental health services across the globe (World Federation for Mental Health (WFMH), 2018).

In the present day, destabilising influences of mental health are often inflated by cultural, social, and economic factors such as poverty, inequality, discrimination, unemployment, unstable family life, social media and its pressures, self-harm, domestic abuse, suicide, substance abuse (namely alcohol and drug misuse), and the polarization between African therapeutic practices and western biomedicine (South African Federation for Mental Health (SAFMH), 2018).

Irrespective of the individual's knowledge or experience with mental health, stigmatising attitudes and beliefs about mental health are still widespread in both society and in the health care profession (Dhai, Gardner and Mahomed, 2021). This has resulted in discrimination in the provision of mental health care. Stigma has been defined by ancient Greeks as an attribute possessed by social outcasts or individuals deemed to have little to no social value such as slaves, whereas discrimination can be defined as the limitation of rights and opportunities, including opportunities to develop capabilities, on the grounds of devalued societal status (Hatzenbuehler, Phelan and Link, 2013).

Due to the colossal discrimination and stigma associated with mental health, there has been a global lack of consensus on the definition of mental health which has had severe implications for mental health care, research, policy, and resource distribution (Manwell, Barbic, Roberts, Durisko, Lee, Ware, and McKenzie, 2015). The WHO definition of mental health has been criticised for its emphasis on the individual's ability to cope and contribute to his or her community as opposed to highlighting the structure of society and its influence on human behaviour and social dynamics (Galderisi, Heinz, Kastrup, Beezhold and Sartorius, 2015).

Community, which links closely with society is paramount in indigenous cultures and value systems (Chuwa, 2012). In the context of mental health, community is an essential concept that can be described as a group of individuals whose mental and emotional states are determined by definitive factors, which require prevention instead of cure. (Bertolote, 2008). Physician and philosopher, Robert Fulford recognized the relative contributions of both biology and social rules on human behaviour, reiterating the complex nature and social design of mental health (Telles-Correia, Saraiva and Gonçalves, 2018).

To propose a more universal definition for mental health, Manwell et al. (2015) collaborated with mental industry experts to investigate the need to redefine the concept of mental health. In their study, Manwell et al. (2015) explored alternative definitions of mental health which, firstly, placed a strong emphasis on the sense of connectedness in a community that embraces diversity and, secondly, built on concepts such as spirituality, human rights, personal dignity, and social justice. An alternative definition of mental health was provided by the Public Health Agency of Canada (PHAC) in 2006 stipulates:

> "Mental health is the capacity of each and all of us to feel, think, and act in ways that enhance our ability to enjoy life and deal with the challenges we face. It is a positive

sense of emotional and spiritual well-being that respects the importance of culture, equity, social justice, interconnections and personal dignity" (Public Health Agency of Canada, 2006).

It was found that the mental health professionals surveyed in the Manwell et al. (2015) study preferred the PHAC definition over the previous definitions provided by the other health organisations, including the WHO.

1.1.2. The Mental Health Context: Brief Overview

In the contextualization of any topic, one ought to analyse and discuss the historical underpinnings, the larger discussion within the topic field, and the social, economic, and political circumstances surrounding the topic (Fullmer, 2016). Thus, to contextualize mental health, it is important to understand the historical circumstances and complexities surrounding mental health care provision. The complexities of mental health can be further understood from its interaction with human rights, health law, and socio-economic development, which are discussed throughout this dissertation. This section in particular provides a brief overview of the mental health burden and the prevalence of mental illnesses. The term 'mental illnesses has evolved into a broad term that also includes 'mental disorders'. However, for the purpose of this dissertation, the term 'mental disorder' is used solely to reflect the language of the classifications, definitions, and frameworks used within the mental health context. It will not be used to label people that have or have experienced mental health conditions.

Mental and behavioral conditions account for approximately 7.4% of the global burden of disease (GBD) and represent the leading cause of disability worldwide (Pike, Susser, Galea and Pincus, 2013). In the 2013 GBD study, at least five types of mental illnesses featured in the top 20 causes of global diseases, namely, major depressive disorder, anxiety disorders, schizophrenia, dysthymia, and bipolar disorder (Global Burden of Disease Collaborative Network, 2013; Vigo, Thornicroft and Atun, 2016). In 2016, the GBD study estimated a 12-month prevalence for the occurrence of any mental, neurological and, substance use (MNS) disorder with a rate of 16.2%, including epilepsy and intellectual disability (Ritchie and Roser, 2018; Docrat, Besada, Cleary, Daviaud and Lund, 2019). In 2018, this rate dropped with MNS conditions accounting for 12% of the GBD indicating a slight improvement in the mental health context (WHO, 2018).

However, the global improvement in the mental health burden and prevalence is limited within the African context. Data analysis from the WHO Atlas Project on mental health reveals a long-term, widespread, and deeply systematic neglect of mental healthcare resources in low- and middle-income countries (LMICs) (Burns, 2011). This disparity persists with LMICs reporting a disproportionately high prevalence of people living with mental illnesses (WHO, 2018). Most LMICs, particularly in Africa, have been plagued with disproportionate levels of conflict, trauma, hunger, poverty, social inequality, unemployment and limited access to healthcare among other social services. These conditions all contribute to the onset and manifestation of mental health conditions (Matlala, Maponya, Chigome and Meyer, 2018).

In 2009, the South African Stress and Health (SASH) study was the first nationwide research conducted on mental disorders (Herman, Stein, Heeringa, Moomal & Williams, 2009). The SASH study confirmed a high prevalence of depression, anxiety disorders, mood disorders, and substance abuse disorders (Matlala, et al., 2018). The studies also found that the prevalence of patients with posttraumatic stress disorders (PTSD) presenting to primary health care facilities was as high as 20% during the early 2000s (Matlala et al., 2018). Furthermore, in South Africa's disease burden study, neuropsychiatric disorders ranked third, preceded by infectious diseases namely, tuberculosis (TB) and Human Immunodeficiency Virus (HIV)/ Acquired Immunodeficiency Syndrome (AIDS). TB and HIV/AIDS are strongly associated with mental illness on the African continent (Amuyunzu-Nyamongo, 2013).

In contrast to mental illnesses, which have been regarded as non-communicable diseases, COVID-19 (Coronavirus disease 2019), malaria, TB, HIV, and AIDS are classified as communicable or infectious diseases (Centre for Disease Control and Prevention (CDC), 2020). While these illnesses differ in their epidemiological nature, they share a common feature in that they are mostly chronic. Chronic diseases have been defined as conditions that last at least one year which require continuous medical treatment and/or limit daily function (CDC, 2020). Therefore, mental illness and other chronic illnesses ought to be monitored and managed throughout an individual's life, particularly when they occur concurrently (Matlala et al., 2018). However, despite these recorded figures, a large gap in the identification and treatment of common mental health conditions at a primary health care level prevails across the South African context (South African Depression and Anxiety Group (SADAG), 2020).

1.1.3. Mental Health Associations, Federations, and Organisations

In addition to health care practitioners (HCPs) and governments, non-governmental organisations (NGOs), mental health associations, and mental health federations work collectively as well as independently to advocate and promote a universal standard of healthcare to improve outcomes in mental health (WFMH, 2018). In 1948, at the International Health Conference in New York, the WHO was established as an international NGO that serves as a health agency for the United Nations (UN) and as an entity serving all countries to ensure the delivery of the UN development system's mandate (WHO, 2019). The UN is the world's largest intergovernmental organisation with the mandate of assessing the global impact of universal health, setting the standards for all aspects of global health, peace, and security (Alarcon, 2009).

In the same year of the WHO's commencement, Dr. George Chisholm, the first Director-General of the WHO, acknowledged that "there is no health without mental health" and, as such, proposed the development of the WFMH (World Federation for Mental Health (WFMH), 2019; Brody, 2004). The WFMH was established at the third International Congress of Mental Hygiene (ICMH) which took place in London and was sponsored by the UN and its associate, WHO (Bertolote, 2008). WFMH replaced the ICMH, and it was intended to provide opportunities for national mental health associations to resume international advocacy, however, this was interrupted by the war period (Brody, 2004). Since 1963, the WFMH has been in consultation with the UN Economic and Social Council (ECOSOC) and is also in official relations with the WHO and the UN Department of Public Information (DPI) (WFMH, 2020).

The WFMH's mandate is to advance the prevention of mental illness, promote quality health care, and protect the human rights of people with mental illnesses, mental disabilities, and people with intellectual disabilities (WFHMH, 2020). In 1971, the World Federation for Mental Health (WFMH) became the first mental health organisation to denounce oppressive, exploitative, and unethical psychiatric practices. Furthermore, 20 years later, the WFMH vehemently opposed UN-endorsed state mechanisms of control (Brody, 2004). Today, the WFMH has 96 mental health national associations and serves as an international, multi-disciplinary NGO comprised of volunteers and former patients with an expanded mandate that emphasizes prevention and treatment of contemporary mental health issues (WFMH, 2020; Brody, 2004).

The International Year of Disabled Persons in 1981 underscored the urgent need to prioritize the rights of persons with disabilities. The Disabled People International define disability as the:

> "loss or limitation of opportunities to take part in the normal life of the community on an equal level due to physical and social barriers" (Section27, 2007).

As a result, the UN World Program of Action Concerning Disabled Persons was formed as a global commitment to persons with disabilities. This programme aims to enhance prevention and rehabilitation of mental disabilities and underscores the equalization of opportunities with regards to full participation and inclusion in social or community life and overall socio-economic development (United Nations (UN), 1975; Rosenthal and Sundram, 2004).

The WHO Department of Mental Health and Substance Abuse provided technical assistance for the development of the World Health Organization's Assessment Instrument for Mental Health Systems (WHO-AIMS) and the WHO Mental Health Atlas Project (Project Atlas) launched in the years 2003 and 2000, respectively (WHO, 2017; Lora and Sharan, 2015). The WHO's Project Atlas was launched to assess country-level data on managing mental and behavioural conditions. The Project Atlas outlines the specific parameters necessary for country-level assessments, namely, policy and legislation; budget; facilities at all levels; human resources; and medication (WHO, 2017). WHO's Project Atlas informs the WHO's Mental Health Gap Action (mhGAP) initiative among a few others, namely, the WFMH's 'Great push for Mental Health' and the Lancet Series on Global Mental Health (WHO, 2017; Lora and Sharan, 2015).

1.1.3.1. Mental Health Associations, Federations, and Organisations in South Africa

Mental health associations, federations, and organisations have made important contributions towards the improvement of mental health outcomes in South Africa (SAHRC, 2017). There has been growing evidence in support of community rehabilitation and reintegration to improve mental health outcomes (SAHRC, 2017). Funding from international agencies, the Department of Health (DoH), and the Department of Social Development facilitate a public-private joint endeavour that has been calculated to work well (SAHRC, 2017).

The Cape Mental Health Society has aligned with the World Dignity Project to eradicate discrimination and stigma, in the provision of mental health care for vulnerable people (Cape

Mental Health Society, 2020). Grounded in principles of equality, non-discrimination, and dignity, the World Dignity Project is a global movement that aims to protect and promote mental health and well-being as a basic human right (World Dignity Project, 2019). Furthermore, the World Dignity Project believes in the integration and prioritization of mental health into primary health care. In preparation for the 2015 World Mental Health Day, the Dignity Symbol was launched in Cape Town, South Africa (World Dignity Project, 2019).

The South African Federation for Mental Health (SAFMH) is one of the founding members of the WFMH and is a civil society organization (CSO) aimed at increasing poor mental health literacy in the country. Mental health literacy has been defined as the knowledge and beliefs about mental disorders that influence decisions regarding care and treatment in the context of mental health (South African Human Rights Commission (SAHRC), 2017). Similarly, the South African Depression and Anxiety Group (SADAG), the former Society of Psychiatrists in South Africa (SPSA), now known as the South African Society of Psychiatrists (SASOP), among other CSOs, work towards improving mental health advocacy and literacy in South Africa.

In addition to health advocacy and literacy, mental health organisations play an important role in bridging the gaps in mental health care, informing multidisciplinary approaches to mental health, and improving the morality of mental health care provision (WFMH, 2018). Furthermore, mental health associations, federations and organisations call upon all members of society to recognize dignified access to mental health care as a basic human right (World Dignity Project, 2019).

1.1.4. The Emergence of Bioethics and Human Rights in Mental Health

In the words of Socrates, moral philosophy is about “how we ought to live” and refers to the study of morality and how morality requires humans to act (Rachels and Rachels, 2019). In terms of mental health, morality is based on how health care authorities, practitioners, and researchers ought to conduct themselves ethically and professionally. Bioethics and medical ethics are similar terms that have often been used interchangeably (Rich, 2015). Bioethics is described as an ethical reflection of various moral issues affecting all living organisms in the biosphere, with an emphasis on the field of health care (Dhai, 2019). Whereas medical ethics specifically focuses on the ethical reflection of moral issues surrounding the provision of human health care and can be described as a division of moral philosophy concerned with the

systematic reflection and critical analysis of human values and behaviour (Dhai and McQuiod-Mason, 2011; Sugarman and Sulmasy, 2010).

The Hippocratic Oath, known as the Golden Rule of medical ethics, underscores the healthcare practitioner's (HCP) primary duty to always act in the best interest of the patient and in a manner that does not harm or put at risk the human rights of individuals in society (Shuster, 1997). Human Rights are fundamental rights entitled to every individual by virtue of being human (Ferlito, 2019). As an academic study, human rights are a combination of legal and non-legal principles entrenched across international, regional, and domestic laws and normative, bioethical frameworks (Goldschmidt, 2017).

The core values of healthcare provide an ethical foundation in healthcare practice and are particularly pertinent to the provision of mental health care (World Medical Association, WMA, 2005; Dhai, Gardner and Mahomed, 2021). Core values in health care include compassion, competence, and autonomy complemented with respect for human rights. Compassion is pertinent to the provision of quality ethical healthcare and is understood as care and empathy towards someone else's distress (World Medical Association (WMA), 2005). Therefore, HCPs ought to envision and empathize with patient's pain in order to provide adequate and appropriate care. The term 'care' has been described in the 2013 South African Council of Nursing (SANC) Code of Ethics as the art of nurturing through the application of professional competencies and positive emotions that create a mutually beneficial harmony between the nurse and the patient (South African Nursing Council (SANC), 2013).

In addition to the above-mentioned core values, deontology and consequentialism are common moral theories applied in healthcare. Deontology is a bioethical framework that evaluates morality in terms of right and wrong actions (Sugarman and Sulmasy, 2010). While Consequentialist bioethical theories, such as Utilitarianism, deem an action right or wrong depending on the benefits or the consequences of that action (Sugarman and Sulmasy, 2010). In healthcare terms, deontological ethics would argue for the HCP to respect the views of the patient regardless of the outcome, whereas consequentialism would require the HCP to make a decision based on the most desired outcome or favourable consequence, i.e., the recovery and well-being of the patient.

However, these moral theories have been widely criticised across societies. Deontology has been criticised for its inability to provide an immediate remedy to moral conflicts (Rachels and Rachels, 2019), whereas Consequentialism has resembled rigorous paternalism as it has not always respected the autonomy of individuals, particularly in the context of mental health. Paternalism refers to the interference from the HCP with the individual's decision-making capacity despite intentions of promoting the best interests of the patient and/or society (Dhai, 2019). Furthermore, utilitarianism has often been used as a scapegoat for human rights injustices as discussed throughout this dissertation. Moreover, it is far too complex to calculate the benefits and risks of the consequences for both individuals and society given the diverse and pluralistic values across communities (Carson and Lepping, 2009; Rachels and Rachels, 2019).

Bioethics emerged and matured internationally from the 1960s as a result of the increasing moral issues faced in the healthcare context (Rich, 2015). The Patient Rights Movement of the 1970s was an instrumental event as it was concerned with releasing patients from medical paternalism (Williams, 2016). Although the Patient Rights Movement was not specific to mental health, it was instrumental in spreading liberal bioethical values and human rights geared towards deinstitutionalisation and community-based health care (Williams, 2016). Psychiatric institutions, formerly referred to as asylums, became discredited from the 1950s due to unethical and inhumane treatment which was rife across these institutions (Telles-Correia, Saraiva and Gonçalves, 2018). Deinstitutionalisation has been defined as a process of alleviating state mental hospitals by transferring patients from institutionalised and hospital care, i.e., secondary and tertiary care, into community-based or primary health care (WHO, 2003).

The distinction between healthcare practice and clinical research has been slightly distorted because oftentimes, they often occur simultaneously. For example, when research is used to evaluate clinical therapy (The National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, 1979). This dissertation focusses on both the healthcare and research context of mental health based on their inter-lapping practices and principles. Understanding the intersection of mental health with bioethical principles and human rights is of growing concern not only for stakeholders and recipients of the healthcare system but for broader society as well. While the description of bioethics in the paragraphs that follow is to health in general, the values and principles analysed apply equally to mental health.

1.1.4.1. Principlism and its application to Mental Health

Beauchamp and Childress describe ethics as a broad term required across all fields of inquiry to examine and understand moral issues in life (Beauchamp and Childress, 2013). Coinciding with the Patient Rights Movement, Beauchamp and Childress published their principle-based framework (also referred to as Principlism) in 1979 (Beauchamp and Childress, 2013). Principlism draws from Hippocratic ethics and has been described as a bioethical framework that underscores four main principles applied in the resolution of ethical dilemmas, namely, respect for autonomy, beneficence, non-maleficence, and justice (Messer, 2003). Gradually over time, these principles have become pertinent to the provision of ethical mental health care.

Autonomy is at the core of bioethical principlism and forms the foundation for informed consent and respect for confidentiality in the context of healthcare (Dhai, 2017). Originating from the Greek language, autonomy is rooted in 'self-rule' or 'self-determination' ("self" – autos; "rule" – nomos) and strongly relates to the concept of dignity (Section27, 2007; Dhai, 2019). Two fundamental conditions hallmark the principle of autonomy, namely, liberty and agency (Dhai, 2019). Liberty is defined as independence from control and influence whereas agency is the capacity required of individuals to make intentional decisions (Williams, 2016). Mental health care patients have often been forced into making decisions where they potentially lack the capacity to provide informed consent, both from a biological and legal or social standpoint –even though a clear way to distinguish this has not yet been established (Lund et al., 2011b). The negative obligation of autonomy states that health care professionals ought not to coerce or influence the decision-making processes of an individual (Dhai, 2019). This is complemented by the positive obligation which requires health care professionals to treat all individuals with respect and promote autonomous decision-making through informed consent (Dhai, 2019).

The principle of beneficence places a moral obligation on the HCP to promote the positive welfare of individuals (Dhai, 2019). The duty of beneficence is inherent in the HCP's role and requires positive steps for the benefit of others. This principle differs from benevolence which refers to wishing good for others (Dhai et al., 2011). Beneficence is usually considered together with non-maleficence which, combined, translates to the benefit and risk ratio (Dhai, 2019).

Non-maleficence is concerned with the risk factor and obligates HCPs to avoid the infliction of harm upon another individual (Dhai, 2019). While HCPs are generally required to live up to certain standards of scientific and medical practice, they are equally expected to be cautious, competent, and compassionate with mental health care patients (Dhai, 2019). Avoidance of harm is often used to describe non-maleficence and in the context of health, the harm principle refers to injury, injustice, and violation. Even if no harm results, failure to act with due care contravenes the principle of non-maleficence (Dhai, 2019)

The justice principle highlights the broader management and distribution of resources across society and the adverse effects on an individual (Dhai et al., 2011). Two fundamental notions of justice can be described as, firstly, the equal treatment of people and, secondly, the fair distribution of burdens and benefits across society (Dhai, 2019). Justice, which is also known as the formal equality principle, mainly refers to distributive justice (Dhai, 2019). Distributive justice applies the second notion of justice, i.e., the fair distribution of benefits and burdens across society, and can be defined as the fair, equitable, and appropriate distribution of resources in terms of social structures such as healthcare and legal systems (Dhai, 2019).

The principles suggested by Beauchamp and Childress are prima facie, meaning that they are equally existing in nature. However, these principles may at times contradict, and overrule each other in strong and extenuating moral circumstances (Beauchamp and Childress, 2013). Healthcare practice is a moral and social agreement between the profession and broader society (Dhai, 2018). Therefore, in determining the morality behind decision-making processes, there is a prima facie duty compelling HCPs and other custodians of health to adhere to, respect, and integrate bioethical and human rights principles and values in their approach to mental health.

1.1.5. Approaches to Mental Health

Mental health and psychiatry are intricately linked and at some point, in time, were used interchangeably (Gillis, 2012). The term ‘psychiatry’ was coined by a French physician in 1808 whereas the concept of mental illness as a disease or disorder only became recognized in the late 1800s (Gillis, 2012). Psychiatry has been defined as the primary treatment of people with mental illnesses or disorders, mental disabilities, and intellectual disabilities (Bertolote, 2008). Neuropsychiatry is the subspecialty of psychiatry that deals with mental disorders at

the intersection of neurology and psychiatry. (Taber, Hurley, & Yudofsky, 2010). To understand the concept of mental health in today's context of health, three models have been used across literature, namely the biomedical model, the biopsychosocial model, and the social model (South African Human Rights Council, 2017).

Biomedicine is defined as a branch of medical science that applies biological and physiological principles to clinical practice (Valles, 2020). Biomedicine co-evolved with western systems through social and economic institutions increasingly since the World War and has expanded through western colonisation, capitalisation, and institutionalisation (Thomas, Bracken, Cutler and Hayward, 2005). As a result, the biomedical model has been the most dominant approach used to diagnose diseases and it continues to prevail across various contexts including that of mental health (SAHRC, 2017).

Psychiatry is considered a biomedical approach to mental health as it uses language such as 'mental disorders' and underscores the presence of a mental 'illness' as the primary concern when dealing with mental health care patients (SAHRC, 2017). Diagnostic and classification tools for mental health conditions include the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association (APA), the International Statistical Classification of Diseases (ICD) and the Psychodynamic Diagnostic Manual (PDM) (Khoury, Langer and Pagnini, 2014). The DSM, which is currently on its fifth version, describes symptoms and other diagnostic criteria pertaining to mental health conditions (van Heugten – van der Kloet and Ton van Heugten, 2015). The DSM-V has been widely accepted and applied within the context of mental health. In 1980, the first formal definition of mental disorder was published in the third edition of the DSM as a significant behavioural or psychological pattern occurring in an individual usually associated with painful symptoms (distress) or impairment in areas of functioning (disability) (Regier, Huhl and Kupfer, 2013). Impairment has been described as a loss or abnormality of psychological, physiologic, or anatomic structure or function which can lead to disability (Telles-Correia, Saraiva and Goncalves, 2018).

In 1977, George Engels outlined four important factors of determining diseases, namely, the patient as an individual, the social context in which the person lives, the doctor's role, and the surrounding health care system (Borrell-Carrió, Suchman and Epstein, 2004). Suffice to say, the complex nature of mental health largely depends on, but cannot be fully reduced to,

biological science. For these reasons, the biopsychosocial and social approaches to mental health emerged (Borrell-Carrió, Suchman and Epstein, 2004).

The biopsychosocial approach to health acknowledges that socio-economic development is an indispensable prerequisite of health that intersects with the social determinants of health (SDH). The SDH can be described as the social and economic conditions that influence the health outcome of an individual or society (SAHRC, 2017). In South Africa's context, some of these social and economic conditions include poverty, unemployment, racial and gender discrimination, violence, poor sanitation, lack of education, limited access to opportunities, inadequate housing, and exposure to toxic environments (Department of Health, 2017).

1.1.5.1. The Social Model: Mental Health and Disability

Psychiatric institutionalisation was a driving force in the overmedicalisation of deeper-rooted social problems, including the intersection of mental health care with socio-cultural and factors such as class, gender, race, and religion. These intersections cannot be separated from socio-economic development. Historically, the discipline of psychiatry was largely criticized for its role in the labelling and overmedicalization of social conditions (Mothibe and Sibanda, 2019).

Antipsychiatry emerged in the late 19th century to eradicate repressive paternalism and unjust institutionalization of people who have been clinically labelled with mental disorders (Telles-Correia, Saraiva and Gonçalves, 2018). This movement was headed by antipsychiatrists such as British psychiatrist R. D. Laing [1927–1989], South African psychiatrist David Cooper [1931–1986], Italian psychiatrist Franco Basaglia [1924–1980], and United States psychiatrist Thomas S. Szasz [1920–2012] (American Psychological Association, 2020). Antipsychiatrists argued for psychiatry that is oriented in social and ethical values, moving away from the use of medicine to enforce social control (Telles-Correia, Saraiva and Gonçalves, 2018). Moreover, antipsychiatrists regarded the concept of 'mental disorder' as a myth based on the fact that in life, there are problems that can trigger psychological suffering which ought not to be categorized as mere diseases (Telles-Correia, Saraiva and Gonçalves, 2018).

According to Rutter and Plomin (1977), any mental illness is always a product of genetics and the environment (Busfield, 2000). Essentially, this means that the spill-over effects of mental illness go beyond the practitioner-patient relationship into the patient's families and broader

society. The social model of mental health accepts the role of biological or chemical determinants of mental health conditions, but it does not regard biological pathology as the sole factor of mental ill-health (SAHRC, 2017). Instead, from the social model perspective of mental health, biological pathology reflects an environment that does not accommodate the needs of people with mental illnesses nor acknowledges the transdisciplinary causes and effects of mental ill-health (SAHRC, 2017).

The introduction of the 'distress/disability' concept in the DSM-3 was instrumental for replacing the previously problematic concept of 'dysfunction' to describe mental health conditions (Telles-Correia, Saraiva and Goncalves, 2018). Furthermore, according to the International Classification of Diseases 10th Revision (ICD-10), all mental disorders are associated with significant disability to the extent that they disrupt individual functioning. This further establishes the relationship between mental health and disability (Regier, Huhl and Kupfer, 2013; Steinert et al., 2016).

Disability is an evolving concept which has become closely embedded with the concept of mental health. This concept is further reinforced by the UN Convention on the Rights of Persons with Disabilities (CRPD) framework. The CRPD conceptualises mental illnesses as disabilities that have been defined as temporary or permanent physical, mental, intellectual, or sensory impairments interacting with various barriers that hinder an individual's capabilities and full effective participation in society on an equal basis with other individuals (UN, 2008).

The CRPD reflects a paradigm shift from a biomedical model to a social model of disability. Furthermore, the CRPD acknowledges persons with disabilities as equal rights holders with inherent dignity (Goldschmidt, 2017). The social model of mental health attributes impairment to the individual's relationship with his or her environment and acknowledges society's failure to promote equitable social inclusion (Spamers, 2016). Based on its direct association with disability, mental health can thus be viewed comprehensively as emotional, social, and psychological well-being which is linked closely to the future development of the overall society (Guse and Vermaak, 2011). The inherent dignity and equal rights of a person, which are recognised through distributive justice, are interlinked principles fundamental to human rights (Goldshmidt, 2017).

1.1.6. An African Bioethical Perspective

Important concepts and principles applied in various approaches to mental health, namely, dignity, spirituality, justice, and community are derivatives of African indigenous value systems (Nare, Ditaba and Mphuthi, 2018). However, the interpretation of bioethical principles may vary between African value systems as the evolving healthcare context is so complex that the strict application of the prima facie notion could render a futile and dangerous process. As history allowed, people with mental illnesses have had little to no bioethical and human rights protections, more so in the African region where western principles have been manipulated to justify inconceivable human rights tragedies (Barugahare, 2018).

Despite the universal application of western-based moral systems, there is a growing call for an African perspective in both academic and professional healthcare contexts (Dhai, 2019). The need for indigenous African Bioethics has resurfaced after years of suppression by colonialism (Chuwa, 2012). 'African bioethics' or 'Indigenous African bioethics' has been understood as moral thought rooted in African values and ought to be expanded to thinking that identifies all ethical principles rooted in African philosophy (Barugahare, 2018). This differs from 'Bioethics in Africa' which is described as the:

> "application of bioethical ideas and moral commitments irrespective of their provenance in the consideration of moral problems emerging from the effects of globalization on healthcare and human wellbeing in Africa" (Barugahare, 2018).

Acknowledging the influence and utility of conventional bioethical principles in African health and well-being, Barugahare (2018) also underscored the hypocrisy of the west to deliberate on bioethical injustices and scientific harms which were caused and inflicted mostly by the very same western practices. Despite this hypocrisy, essential western-based moral theories and principles have been welcomed and integrated into the African perspective (Dhai, 2019). Notwithstanding, the African perspective has been distorted by its own indigenous injustices. To argue for a sound ethical value system, a logical conclusion or outcome needs to follow a set of assumptions or claims that are true. However, variations of what is considered true has been inconsistent across the global context. Therefore, the balance between African value systems and western bioethics is crucial for the mitigation of biased

and discriminatory perspectives, as well as for the achievement of a universally sound ethical value system.

1.1.6.1. The Spirit of Ubuntu across Indigenous Value Systems

The principle of autonomy in the African context has been expanded to underscore the interconnectedness and interdependency of a person's dignity, rights, and freedoms with the rest of the community (Chuwa, 2012). This dynamic of interconnectedness and interdependency is supported by the indigenous African principle of Ubuntu (Dhai, 2019). The principle of Ubuntu is described in the works of John Mbiti who interprets it as:

> "I am because we are, we are therefore I am" (Chuwa, 2012)

The term Ubuntu is derived from South African Nguni languages, i.e., isiZulu, isiXhosa and isiNdebele, however, phonological variants of the term are used across various indigenous African societies based on the communitarian ethical value of this principle (Chuwa, 2012). In the SeTswana/SeSotho cultures of South Africa, Ubuntu translates to *'botho'* and phrased as:

> "motho ke motho ka batho" (Chuwa, 2012).

In direct English terms, this means *a person is a person because of people*. Likewise, this philosophy is expressed by the Swahili people of East Africa as '*Utu'*. The Kikuya from Kenya, express it as '*Umundu*', slightly differing from '*Umuntu'* of the Merians. Furthermore, in Tanzania, people of the Chagga, also known as Chaga, culture express the principle as '*Undu'* whereas the Sukuma people of North Tanzania use the term '*Bumuntu'* (Chuwa, 2012).

Ubuntu reflects an important shift from the individualistic western philosophy to communitarian ethics. For generations, Ubuntu has formed the praxis of African philosophy, informing the lifestyle and worldview of many African communities (Chuwa, 2012). Furthermore, this spirit of Ubuntu plays a vital role in African indigenous moral systems as it reinforces the principle of justice. In the SeTswana culture, community members convene in what is known as *Lekgotla* to deliberate on opportunities and risks for individuals within a community (Mokotong, 2018). This type of juridic deliberation and decision-making

demonstrated in the *Lekgotla*, can be likened to the administrative process of a research ethics committee (REC).

Moreover, the principle of Ubuntu embodies and prioritizes human dignity and the principle of justice in society before considering economic, financial, and political factors (Dhai, 2019). This is especially true for conditions affecting health and well-being as articulated by Martha Nussbaum in her notion of Ubuntu which states:

> "Your pain is my pain, my wealth is your wealth, [and] your salvation is my salvation" (Nussbaum, 2003).

As mentioned in section 1.1.1., community links closely with society. The requirement of community involvement is important for dignity and social justice but is limited by language and cultural barriers particularly in the provision of biomedical mental health care (Engelbrecht, 2014). Therefore, a sound awareness, sensitivity, and empathy towards an individual, including his or her cultural values and beliefs, is pertinent to the provision of healthcare that is ethical and respects human rights.

Mental health care, bioethics, and culture are intricately related (Chuwa, 2012). Cultural competence has been deemed an essential component in the context and provision of mental healthcare and has been described as ethical provision of health care that is aware, sensitive and empathetic towards the patients and his or her cultural beliefs (Chuwa, 2012; Jinger, Hoop, DiPasquale, Hernandez & Weiss Roberts, 2008). This is attributable to the fact that healthcare is culturally nuanced with its roots in indigenous and community practices (Jinger et al., 2008)

1.1.7. The Capabilities Approach

A healthy society, as opposed to waiting for people to become ill, takes proactive measures to prevent and mitigate health issues for the current and future generations namely through prioritising cultural, commercial, economic, environmental, political, and social investments towards improving health outcomes (The Health Foundation, 2018). As the PHAC definition suggests, mental health is more than the mere absence of mental illnesses. Instead, the concept of mental health has been expanded to include notions such as subjective well-being, autonomy, competence, intergenerational dependence, spirituality and the recognition of the individual's ability to recognise one's intellectual and emotional potential (PHAC, 2006;

WHO, 2003). To operationalise this potential, the development of one's capabilities is essential.

The Capabilities Approach is a normative theory based on human rights justice. Nobel prize winner and economist, Amartya Sen, and philosopher, Martha Nussbaum, recognized that for an individual to fully realise their rights and make use of their capabilities, dignity ought to be operationalised (SAHRC, 2017). In the context of mental health, capabilities are enhanced by the bioethical principles of autonomy and justice as well as the legal principle of equality. In this sense, capability refers to the positive duties of a state to ensure a minimum threshold of functioning through equitable distribution of resources (Goldschmidt, 2017). Equity, from an ethical and economical viewpoint, implies that everyone should have a fair opportunity to attain their full health potential and that no one should be disadvantaged from achieving this potential due to social and economic challenges (Mangalore and Knapp, 2006).

In the context of mental health, inequity exists in accessing quality care, poor outcomes of mental health care, i.e., disproportionate morbidity and mortality rates, and unfair distribution of resources (Goldschmidt, 2017). In the South African context, these health inequities exist against the backdrop of broader social, cultural, economic, and political injustices (Nguii, Khasakhala, Ndetei and Roberts, 2010). To determine what quantifies the fair and equitable distribution of resources, three main principles are applied, namely rights, capabilities, and needs (Mangalore and Knapp, 2006). Rights, claims, or liberties of citizens stem from publicly acknowledged rules and ought to be guaranteed and protected by every country. Capabilities are measured by an individual's moral virtues and productive efforts. This principle has less appeal in quantifying distributive justice in the mental health context based on the biopsychological nature and impact of mental illnesses, whereas needs have a much greater appeal to invoke claims of distributive justice as they form the basis of rights and capabilities (Mangalore and Knapp, 2006).

However, in the mental health context, it becomes more of a challenge to improve access to justice considering the global disproportionate distribution of mental healthcare resources, particularly in developing countries (Mangalore and Knapp, 2006). This inequity is an infringement on the human right to access health care, which includes mental health. Furthermore, one's capability to be healthy is limited when social and economic injustices that infringe upon a person's dignity and freedom are left unaddressed (Venkatapuram, 2007). As a result, Sen and Nussbaum developed the Capabilities Approach for evaluating justice,

whereby individual capabilities or freedoms need to be maximized to achieve certain functioning (Mitchell, Roberts, Barton and Coast, 2016). Freedoms are, or at least ought to be, constitutionally protected and can include capabilities such as choice or informed consent (Mangalore and Knapp, 2006). Freedoms and capabilities need to be supported by entitlements such as access to equitable socio-economic opportunities to enable the realisation of human rights (Dhai, Gardner and Mahomed, 2021).

1.1.8. Socio-economic development and Mental Health

Growing global evidence has revealed that mental ill-health and poverty interact in a negative cycle, particularly in low- and middle-income countries (LMICS) (Lund, De Silva. Chrisholm, Plagerson, Cooper, Das and Patel, 2011b). This establishes the relationship between socio-economic development and mental health which have a cause-and-effect relationship with each other. In 2015, the United Nations Development Programme (UNDP) and 193 member nations, including South Africa, committed to the implementation of the UN Sustainable Development Goals (SDGs) which are outlined in the 2030 Agenda for Sustainable Development (UN General Assembly, 2015).

The SDGs replace the previous 2000 – 2015 Millennium Development Goals (MDGs). Although both premised on the alleviation of poverty, he MDGs were unsuccessful mainly because they did not establish the relationship between mental health and socio-economic development (McGovern, 2014). The SDGs envisage a global community with equitable and universal access to basic human rights such as good quality education, healthcare, and full social protection that prioritizes mental, physical, and social well-being (UN General Assembly, 2015). One of the ways in which the UN SDGs seek to reduce poverty is through addressing the disproportionately weak response to mental health, among other social injustices (UN General Assembly, 2015).

The disproportionately weak global response to mental health has been attributed to the global imbalance between disease burden, financing, and service delivery (Vigo, Thornicroft and Atun, 2016). Disease burden determines the prevalence of disease and disability within the public health context. Disease burden is defined as “the gap between current health status and an ideal situation in which everyone lives into old age free of disease and disability” and the gap is influenced by premature mortality, disability, and exposure to certain risk factors

contributing towards the onset of an illness (Institute of Medicine, 2010). SDG 3 aims to ensure healthy lives and promoting well-being for all ages, making the commitment in 3.4 to:

> "…reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being" (UN General Assembly, 2015).

Although the relationship between severe mental illness and mortality is not widely recognized, injustices within the mental health context have generated public outcry across many societies (Dhai, Gardner and Mahomed, 2021). Mental health is heavily influenced by both medical and societal factors and, as a result, it intersects with most, if not all, of the SDGs (Vigo, Thornicroft and Atun, 2016). The SDGs acknowledge that Universal Health Coverage (UHC) is an essential development priority in the provision of mental health services (Tandwa 2018).

Regionally, Agenda 2063 is the strategic framework that, essentially, translates the SDGs to the African context whilst maintaining the objectives and values of the Pan African Vision of an integrated, prosperous, and peaceful Africa (The African Union Commission, 2020). The aim of Agenda 2063 is to promote sustainable socio-economic development in Africa which requires integrative transformation. For successful integration, Agenda 2063 calls for increased engagement and collaboration among African nations (The African Union Commission, 2020). Priority areas of Agenda 2063 include poverty, inequality, and social security with an emphasis on protecting persons with disabilities. Furthermore, Agenda 2063 prioritizes and promotes respect for human rights and universal access to social justice and the Rule of Law (The African Union Commission, 2020).

1.1.9. African Traditional Medicine and Indigenous healing

For most of the African region, ancestral and traditional beliefs strongly influence mental health (Zingela, van Wyk and Pietersen, 2019). Ancestors are the people, or rather the spirits of our forebearers, that guide and perform spiritual healing through their living descendants (Ka Luphuzi, 2010). Indigenous healing practices formed part of African cultural and healthcare prior to the arrival of western medicine (Mothibe and Sibanda, 2019).

The WHO defines African Traditional Medicine as:

> "The sum total of all knowledge and practices, whether explicable or not, used in diagnosis, prevention and elimination of physical, mental, or societal imbalance, and relying exclusively on practical experience and observation handed down from generation to generation, whether verbally or in writing." (Section27, 2007).

In essence, ATM and traditional healing practices underscore the importance of holistic health hence have been grounded in a community perspective (Sorsdahl, Stein, Grimsrud, Seedat, Flisher, Williams and Myer, 2009; Mothibe and Sibanda, 2019). Moreover, according to the WHO Composite International Diagnostic Interview (CIDI), traditional healers continue to play a major role (Sorsdahl et al., 2009).

In 2001, the WHO African Regional Strategy on Traditional Medicines was promulgated, of which the AU is a signatory. The years 2001 – 2010 were declared the Decade for African Traditional Medicine and the annual celebration was declared as 31st August. However, a decade later, the formal integration of ATM into national health systems was still grossly underprioritized (Mothibe and Sibanda, 2019). As a member of the WHO, South Africa has also attempted to formalise ATM practices into national health care. ATMs play a very important role in the South African context and ought not to be replaced with western biomedicine (Mothibe and Sibanda, 2019). Furthermore, SASH studies revealed the widespread use of traditional health practices, particularly among individuals with mild mental health conditions. While severe mental disorders and psychotic disorders would be delegated to Western biomedicine, i.e., psychiatry (Zingela, van Wyk and Pietersen, 2019).

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It is noteworthy that both conventional (biomedicine) and traditional (indigenous) forms of healthcare make valuable contributions to South Africa's health system (Section27, 2007). One of the most fundamental healthcare recommendations from the WHO's CIDI and the SASH was to integrate specialised mental health services into primary health care (The World Health Organization and Wonka, 2008).

1.1.10. Universal Mental Health Care through Primary Health Care

At an international, regional, and national level, people with mental health conditions have been exposed to a plethora of socio-economic challenges, namely, lack of access to essential services such as education and healthcare; high levels of unemployment; discrimination; stigma; dangerous research; unethical treatment and the lack of integration of mental health

care services into primary health care (PHC) (Vigo, Thornicroft & Atun, 2016; SAFMH, 2018).

In the 1978 Alma Ata Declaration, Primary Health Care (PHC) is defined as:

> "essential healthcare based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination.
>
> It forms an integral part of both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community.
>
> It is the first level of contact of individuals, the family and community with the national health system bringing healthcare as close as possible to where people live and work and constitutes the first element of a continuing healthcare process" (WHO, 1978).

A PHC approach would primarily focus on the person as an individual as opposed to the current, disease-centred approach that exists in mental health. PHC interventions are targeted at the whole community or society and are grounded in activities such as health promotion, disease prevention, treatment, rehabilitation, and palliative care (WHO, 2020). The 2018 Global Conference on Primary Health Care, taking place on the occasion of the 40th anniversary of the Declaration of Alma-Ata, introduced the Astana Declaration to commemorate and reaffirm the original principles of the Alma Ata Declaration. Furthermore, this conference served to renew political commitment towards placing PHC at the foundation of achieving UHC through the SDGs (Kraef and Kallestrup, 2019).

To address the vulnerability in accessing mental health care, Universal Health Coverage (UHC) is necessary to provide healthcare for all populations through the enrolment of a health-based social security system to ensure equitable access and benefits of health for all individuals (Abiiro and De Allegri, 2015). South Africa's National Health Act 61 of 2003 (NHA) legislates for a national health system that incorporates the public and private sectors for the equitable provision of health care services (Coovadia, Jewkes, Barron, Sanders and McIntyre, 2009). In the realisation of the right to access mental health, the Mental Health

Care Act No. 17 of 2002 (MHCA) was implemented in 2004 and is regarded internationally as one of the most progressive legislations (Burns, 2011). The Preamble of the MHCA recognizes that mental health is integral to obtain holistic health and requires that mental health services be provided as part of primary, secondary, and tertiary health services (Republic of South Africa, 2004).

South Africa's promise to achieve UHC is enshrined in the National Health Insurance (NHI) policy which encapsulates the global vision that health is, in fact, a "social investment" and developmental priority (Department of Health, 2017). The NHI recognizes that PHC is integral to any country's health system as it is the main focus contributing to the overall socio-economic development of the community (Department of Health, 2017). However, major socio-economic disparaties persist across South Africa's mental health system as specialist psychiatric services and hospital services, i.e., secondary and tertiary levels of care, receive the largest proportion of the mental health budget and the largest allocation of mental health resources (SAHRC, 2017).

As a result, many South Africans are vulnerable as they do not have adequate access to health care services, particularly PHC (SAHRC, 2017). Vulnerable communities or groups are defined as groups at risk of experiencing harm and/or exploitation (Solbakk, 2015; Dhai, Gardener and Mahomed, 2021). Vulnerability refers to a state of physical, emotional, cognitive, and social stability that is threatened by or susceptible to destabilizing influences (Boldt, 2019). Destabilising influences in mental health care have socio-political roots and have been grounded in negative attitudes, discrimination, prejudice, and stigma. In the context of mental health, these destabilizing influences cross medical boundaries and interact with social and economic influences. As a result of socio-economic injustice, disproportionate resource allocation as well as historical and present-day inequalities embedded within South Africa's society, quality healthcare is not always accessible nor attainable for people with mental health illnesses and disabilities (Berger, Hassim, & Heywood, 2007).

The biomedical approach to mental health has played an important role in the provision of mental health care services and treating mental health conditions. However, a major disadvantage of the biomedical model is that it does not address the underlying social factors of mental ill-health and provides only partial solutions to over 75% of the problems presented in Primary Health Care. Furthermore, a strictly biomedical model of mental health has been disadvantageous as it has often led to the overmedicalization of social, cultural, and economic

issues in society. This has resulted in the increased need for a community- and human rights-based approach to the provision of mental health care services, particularly in the South African context (SAHRC, 2017).

1.2. Research Question

Is there a bioethical imperative to prioritize mental health care provision in primary health care services in South Africa?

1.3. Rationale for Study

The historical and current frequency of human rights violations in the mental health care context has exacerbated the vulnerability for MHCUs and mentally ill patients. Despite the emergence of bioethical and human rights protections, intergenerational distributive injustices have limited the right to access quality mental health care. Reviewed studies suggest that human rights-based approaches can lead to improved health outcomes and socio-economic development (Mann, Bradley, Sahakian, 2016). There has been no bioethical analysis thus far that explores the need to prioritize mental health care in the primary health care setting. Therefore, this dissertation addresses this knowledge gap from a bioethical and human rights perspective.

1.4. Thesis Statement

Bioethics principles and human rights tenets provide justification for the prioritization of mental health care in primary health care services in order to improve the wellbeing of mental health care users and patients.

1.5. Research Aim

To critically analyse from a bioethics and human rights perspective whether mental health care should be prioritized into primary health care services in order to improve the well-being of persons with mental health problems in the country.

1.6. Research Objectives

1. To critically discuss the role of history and its influence on current day attitudes and perceptions in the context of mental health from a bioethical and human rights perspective.

2. To critically analyse mental health protections in respect to the right to health and non-derogable human rights.
3. To critically analyse the intergenerational vulnerability in mental health, with an emphasis on the African context.
4. To critically evaluate mental healthcare provision in the context of primary healthcare in South Africa.

1.7. Research Design

This study is purely normative. Normative ethics forms part of the "three basic types of ethical inquiry" and has been described as a branch of philosophical or theological inquiry that sets out to answer critical questions (Sugarman and Sulmasy, 2010). Normative ethics has been at the core of ethical inquiry and sets out to answer moral questions in a systematic, critical fashion and to justify the answers offered (Sugarman and Sulmasy, 2010). The normative ethical questions addressed in this dissertation include: Ought mental health care be prioritized at the level of primary health care in South Africa? What ought to be done to respect the human rights of mental healthcare patients and users in South Africa? What ought to be done about the inequitable provision of mental health care services in South Africa? What sort of mental health care system ought we to strive towards in South Africa? How ought the link between mental health care and socio-economic development be established in South Africa?

1.8. Research Methods

This study was purely normative; hence it was conducted using desktop and library-based research, with no collection or analysis of new empirical data. There was no involvement of human participants. The typical research methods and standards applicable to philosophical research were employed. The research provided a bioethical and legal analysis of the literature findings through interpretation and critical analysis of pertinent texts, postings, and government legislation to answer the research question. Definitions and clarifications of relevant concepts form part of the analysis, as well as the identification, evaluation, and critique of normative theoretical frameworks. Lastly, the sources used for this research included but were not limited to, Google, the Wits e-databases, PubMed, Government legislation, international frameworks, and other academic search engines. (Faculty of Science, 2017).

1.9. Argumentative Strategy

This dissertation applied a combination of western-based moral frameworks and African value systems. These include Principlism, Ubuntu as well as several of the normative Bioethical and Human Rights principles. Distributive injustice in South Africa has resulted in a deeply fragmented mental health care system that is reminiscent of its colonial underpinnings where vulnerable groups were subjected to discriminatory and limited access to mental health care. This dissertation provides a critical analysis of the intergenerational vulnerability experienced by MHCUs and mentally ill patients as a result of socio-cultural, socio-economic and socio-political injustices. In doing so, a thorough analysis of international, regional and national mental health protections is provided to critically assess the right to access mental health care. This dissertation mainly argues for the deinstitutionalisation of mental health care to primary health care and community-based services through prioritized socio-economic investment for mental health. The argument of this dissertation is premised, firstly, on bioethical principles such as autonomy and ubuntu which are necessary for capacity and socio-economic development. Secondly, this dissertation is premised on the formal collaboration and integration between African indigenous healing systems and western biomedical approaches. The prioritization of equitable and universal access to mental health care is therefore necessary for holistic healing and to improve socio-economic development in South Africa.

1.10. Chapter Outline:

Chapter 1 introduced the research and provided the background literature analysis and critique for this research. In addition, chapter 1 outlined the research question, rationale for study, thesis statement, research aim and objectives, research design and method, as well as the argumentative strategy used. Chapter 2 describes the historical underpinnings of bioethics and health law, with reference to the Nuremberg Code and the Mental Hygiene Movement. Chapter 3 provides an in-depth analysis of the historical development of psychiatry in South Africa with reference to the evolving laws at the time. Chapter 4 provides a multilayered analysis of mental health protections from human rights, bioethics and health law perspective.

Chapter 5 critically analyses mental health vulnerability in the African context with specific reference to tragedies in deinstitutionalisation. Chapter 6 outlines the prioritization of universal access to mental health care through socio-economic development and socio-cultural integration. Chapter 7 concludes this dissertation and provides recommendations and conclusions for prioritising mental health care in primary health care in South Africa.

1.11. Ethics

As this dissertation did not involve human participants, an ethics waiver was granted by the Wits Human Research Ethics Committee (Medical).

1.12. Funding

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Chapter 2: Historical underpinnings of Bioethics and Human Rights in Mental Health

The promulgation of ethical codes stems from biased and inhumane practices within the social and medical context. The historical underpinnings of bioethics and human rights, therefore, become useful to inform our understanding of the current mental health context and to interpret essential principles relevant to accessing mental health care services. In response to objective 1, this chapter provides a critical assessment of the historical influences on current day attitudes and perceptions in the context of mental health from a bioethics and human rights perspective.

2.1. The 1847 Code of Ethics

Before the emergence of bioethics and human rights, western psychiatric care was characterized by abusive treatment, unethical imprisonment, torture, and other inhumane and restrictive treatments that were enforced across many asylums (Minde, 1974). Historical atrocities sparked international revolutions, calling for a paradigm shift in the context of bioethics and human rights (Shuster, 2018).

In 1847, the American Medical Association (AMA) published its Code of Ethics, which was inspired by, and entrenched with Hippocratic values. This was the first bioethical code to be adopted by a professional national organisation within the western biomedical context (American Medical Association (AMA), 1847). However, during this time, medical ethics were negatively skewed as they were built upon biased socio-cultural and socio-political narratives, namely racial, religious and colonial ideologies (Ure, 2009).

Prior to the 20th century, technical references to mental health as a field or discipline of study did not exist because people with mental illnesses were stigmatised as outcasts of society and, in the eyes of several religious communities, were viewed as a punishment sent from God and considered as a "sign of moral dirtiness" (Žalnora and Miežutavičiūtė, 2016). In the 18th century, social movements against torture, slavery, cruel punishment, and unnecessary confinement of persons with mental illnesses, who were referred to as 'lunatics' at the time, contributed to the bioethical and human rights discourse in mental health (Carpenter, 2009).

2.2. The Nuremberg Code

Despite global social movements, the 1900s witnessed the spread of unethical and inhumane physical experiments on people with mental illnesses (Gillis, 2012). Throughout history, people with mental illnesses were often unwilling or unknowing participants in research (Gillis, 2012). These physical treatments comprised toxic injections of convulsive therapies, namely, cardiazol therapy to treat manic depressive psychoses, insulin treatment of schizophrenia, seizures induced through electroconvulsive therapy, and the induction of hypoglycemic comas using malaria parasites which researchers believed would be effective in treating schizophrenia (Gillis, 2012). Moreover, several extensively prescribed medications, which were purported to treat mental illnesses, such as bromides would often cause psychoses in these patients with mental health problems (Minde, 1974).

The Nuremberg Code was developed in 1947 by American judges from the International Military Tribunal presiding over, what was known as, the Nuremberg Trials (Shuster, 1997). While this code was not directly related to mental health, it contributed significantly to the emergence and reinforcement of global human rights laws and bioethical protections. Entrenched in Hippocratic ethics, the Nuremberg Code underscores respect for autonomy in Article 1 which stipulates:

> "the voluntary consent of the human subject is absolutely essential" (Nuremberg Tribunal, 1996).

Autonomy has been emphasized in the Nuremberg Code because this vital principle ought to protect individuals from invasive paternalism and restore freedom of choice and liberty among individuals (Williams, 2016). Beauchamp and Childress analysed the concept of autonomy with the main consideration of social influences. Despite its significance in modern medical ethics, the interpretation of and access to autonomy still varies across different contexts. For example, in deontological ethics, intelligibility determines the liberty of an individual while neuroethicists and psychiatrists determine an individual's liberty through the absence of a mental disorder (Muller, 2017). Therefore, it may be necessary to simultaneously consider the social and neurobiological determinants influencing autonomy (Muller, 2017).

In the healthcare context, there has been a paradigm shift towards recognizing the agency of patients and promoting the rights of individuals. Beauchamp and Childress identify intentionality, understanding, and non-control as the conditions required for autonomy

(Beauchamp, 2003; Tandwa, 2018). Individuals who lack autonomy have been identified as immature, incapacitated, ignorant, coerced, or exploited and, as result, cannot provide consent (Muller, 2017). During the Nuremberg Trials, the doctors claimed they were forced by the German Nazi state to conduct atrocious and unconsented experiments and further added that the unethical research was for the "good of the state" (Shuster, 1997). It almost seems as if, based on the Nazi doctors' justification, paternalistic nationalism can be used to justify human rights violations under the auspices of utilitarianism.

Utilitarianism judges the rightness or wrongness of actions based on their outcome and whether the principle of utility is utilized (Dhai, 2019). Based on the principle of utility, utilitarianism requires us to produce the most happiness for the most amount of people and draws from the harm principle as follows:

> "the only purpose for which power can be rightfully exercised over any member of a civilized community against his will, is to prevent harm to others*"* (Dhai, McQuiod-Mason and Knapp van Bogaert, 2011; pg. 15)

Similar to the principle of non-maleficence, the principle of utility also requires an action to produce the least amount of harm or no harm at all (Rachel and Rachel, 1986). However, this was not the case for the Nazi state and doctors thus rendering their so-called consequentialist defense futile. Despite the widespread criticism for its poor mitigation against unjust and disproportionate social distributions, utilitarianism plays a major role in the development of human rights laws and policies, as well as ethical codes of conduct (Dhai, 2019).

In any other medical field, unconsented and invasive research and treatments were deemed ethically inappropriate whereas, in mental health, involuntary treatment and unconsented research were a trend. By the nature of most mental illnesses, autonomy is already compromised. Although not legally binding, the Nuremberg Code is considered the most important document in modern medical ethics as it promotes the protection of the human rights of research participants and health care users (Shuster, 1997). While its initial purpose was for the protection of the rights of research participants, the Nuremberg Code has significantly influenced many human rights and ethico-legal codes applied in the current health context (Dhai and Etheredge, 2011).

2.3. The Era of Enlightenment and its influence on Bioethics and Mental Health

The Era of Enlightenment, also referred to as the 'Age of Reason', is described as a European intellectual movement that underscored notions about God, reason, nature, and humanity. These notions were developed into a western worldview that influenced art and philosophy (Peters, 2018). The Era of Enlightenment has been divided into three phases, namely the Early Enlightenment [1685–1730], the High Enlightenment [1730–1780], and the Late Enlightenment [1780–1815] (Peters, 2018). The Age of the Late Enlightenment of the late 18th century coincided with the emergence of bioethics and recognized the importance of eradicating ignorant and negative attitudes towards mental health.

It can be said that the Era of Enlightenment was instrumental in spreading the spirit of humanism and the emergence of principles such as liberty, equality, and community (Rachels and Rachels, 2019). These principles are particularly important in the context of mental health. Throughout the Enlightenment era, industrial capitalism exacerbated the increase of middle-class economic and political power with a primary focus on individual liberties and property rights (Carpenter, 2009). These principles have been linked and expanded with the historical development of psychiatry in South Africa, as depicted later in this chapter.

Historically, individual liberty was considered a negative human right, that had a paradoxical effect on social discipline (Carpenter, 2009). The irony was that liberty, at least at the time, contradicted the principle of autonomy as it was heavily entrenched in ideas of self-control through restrictive methods deployed in the context of mental health (Carpenter, 2009). As outlined in chapter 1, liberty hallmarks the principles of autonomy and justice, which are indispensable for the provision of mental health care.

Moral philosopher, Immanuel Kant dominated the so-called Late Enlightenment period with the publications of his critique on pure reason, practical reason, and the critique of judgement. Kant grounded his moral philosophy in the bioethical principle of autonomy and encouraged public reason through free-thinking (Peters, 2018). This introduced a shift in the meaning and philosophical nature of the principle of liberty. Kant's work, also referred to as Kantianism, has been echoed throughout deontological philosophy, having influenced equality, specifically, women's rights (Peters, 2018). Deontology is a normative moral theory that determines the morality of an action, as dependent on the nature of the action, regarding any

form of harm as unacceptable, despite the justified consequences (Mandal, Ponnambath and Parija, 2016).

Human Rights such as the right to freedom of expression, personal liberty, dignity, and protection from arbitrary power date back to ancient times. However, efforts to entrench these rights within a constitutional and democratic system only came about towards the end of the 18th century, partially influenced by the French and American evolutions during the Enlightenment period (Carpenter, 2009). Moreover, the relationship between mental health and human rights was only taken seriously towards the end of the 19th century after the emergence of one of the most popular movements in mental health, namely, the Mental Hygiene Movement which started in the United States of America (USA) as a demonstration of so-called enlightened approach in the context of mental health (Žalnora and Miežutavičiūtė, 2016; Ure, 2009).

2.4. The Mental Hygiene Movement: International Overview

Heavily influenced by the social climate of the pre-and interwar periods of the 20th century, the Mental Hygiene Movement was regarded as a revolutionary attempt to overcome social diseases and hardships associated with mental health (Žalnora and Miežutavičiūtė, 2016). Mental Hygiene was the term used before mental health and was first defined in 1843 as "an examination of the intellect and passions designed to illustrate their influence on health and duration of life" (Bertolote, 2008). The term 'Mental Hygiene' resulted from the lack of distinction between definitions of criminal, behavioural, and mental illness as no clear definitions were present except those provided by religious institutions (Ure, 2009).

In addition to demonstrating the complex relationship between social and mental health, the Mental Hygiene Movement was imperative for the development of psychiatric, among other medical services within the discipline of mental health, which is considered as one of the youngest branches of medical sciences (Žalnora and Miežutavičiūtė, 2016). In 1908, Clifford Beers, a key driver of the Mental Health Movement, published his book titled, 'A mind that found itself', which underscored his personal traumatic encounter with the mental health care system after being institutionalized for depression and paranoia (Brody, 2004). After his interaction with psychiatric institutionalization, Beers was determined to "humanise the care of the insane" through the formation of the Mental Hygiene Society which, soon afterward,

established the National Committee of Mental Hygiene (NCMH) in 1909 in the United States (Bertolote, 2008).

During the period between 1910 and 1936, the NCMH extended its scope to focus on preventative work and to accommodate milder forms of mental disabilities (Brody, 2004). The Mental Hygiene Movement gained serious traction leading to the globalization of the Mental Hygiene Committee and the expansion of its national associations to countries such as France, South Africa, Italy, and Hungary (Bertolote, 2008). Internationally, the Mental Hygiene Movement encouraged and allowed for a deeper engagement of the social issues intersecting with the mental health context. To move away from harmful and unethical paternalism in psychiatry, the Mental Hygiene Movement placed a strong emphasis on adopting a community approach to mental health moving away from a single patient-centred approach (Brody, 2004).

2.4.1. The Mental Hygiene Movement in South Africa

This section draws substantively from the work done by Dr. Gale Ure in 2009. In South Africa's context, the Mental Hygiene Movement only served to formalise socially discriminatory practices. The South African Council for Mental Hygiene was formed in 1920 to regulate the treatment of medically termed 'delinquents' for criminal court (Ure, 2009). These delinquents were identified as poor whites, unemployed, and substance users and were often deemed dangerous and, as a result, were separated from society. This was one of many demonstrations of the overlaps between medical and social domains, reinforcing both the medicalization of social problems and the criminalisation of mental health (Ure, 2009).

The Eurocentric or western view that black Africans are 'primitive' was widely reflected in the treatment modalities developed during this time (Ure, 2009). Social and medical engineers such as T.J. Dunston, Henrik F. Verwoed, and W. Darley-Hartley, played major roles in the formation and expansion of socially discriminatory ideologies under the Mental Hygiene Movement in South Africa (Ure, 2009). Dunston encouraged harmful and discriminatory eugenic practices to address 'insanity' and occupied the role of Commissioner of Mental Disorder and Defective Persons (1916), which was later changed to the Commissioner of Mental Hygiene. Eugenics has been described as the science of controlling the manifestation of desirable or undesirable hereditary traits in society (Garver and Garver, 1991). According to unsound eugenic theories, the genetics of black and poor people ought to be ameliorated

from society as they possess undesirable traits, namely, low intellectual disability and pauperism, as alleged by the colonial state in South Africa (Ure, 2009).

Moreover, Dunston had a major influence on South African health law and policymaking, playing a primary role in the promulgation of the Mental Disorders and Defective Persons Act 38 of 1916 which is detailed in Chapter 3 section 3.3. Verwoed, who publicly appraised Germany's unethical experiments on people with mental illnesses, endorsed the use of racist social science to implement judicious control over members in the South African society (Ure, 2009), whereas Hartley was a former member of the Colonial Medicine Council, an active member of the British Medical Association (BMA) and was the founder, editor, and publisher of the South African Medical Review, through which he helped the Mental Hygiene Movement gain traction (Ure, 2009).

In 1927, the Medical Association of South Africa (MASA) gained its independence from the BMA (Ure, 2009). This was a positive step for bioethics as concern grew around the substantiation of scientific research methods used during this time. Furthermore, socio-scientific developments largely influenced social welfare committees comprised of psychologists, social workers and religious leaders (Ure, 2009).

During the Mental Hygiene Movement, issues relating to neurology, psychiatry, social work, psychology, intellectual disability, and behavioural challenges were framed under the blanket term of medicine, despite the socio-economic entanglements (Ure, 2009). The entwining of medicine with socio-economic and socio-political developments has had deleterious consequences on South African mental health policymaking and livelihood.

2.5. Conclusion

The 1847 Code of Ethics formalised essential Hippocratic values calling for a paradigm shift in socio-cultural and socio-political narratives. The Age of Enlightenment of the late 18th century recognized the importance of fighting ignorance and negative attitudes towards mental health. However, despite this so-called enlightenment, socially discriminatory practices in mental health were solidified and adopted across the globe as observed by the events leading to the promulgation of the Nuremberg Code as well as the Mental Hygiene Movement in South Africa. Global historic human rights atrocities made it evident that robust protections were, and still are, required to guarantee the protection of human rights, particularly the rights of people with mental health conditions.

Chapter 3: The Historical Development of Psychiatry in South Africa

South Africa's historical period reveals an important correlation between the emergence of colonial psychiatry and socio-economic development. This relationship has had a significant yet disproportionate influence on South Africa's current mental health and socio-economic contexts. The phases of psychiatric development in South Africa have been categorized into three stages, namely, The Period of Expediency and Restraint, The Psychiatric Hospital Phase, and Modern Psychiatry, as we know it today (Gillis, 2012). This chapter draws on history to locate the patterns that emerge in the context of mental health. History can do much to enrich the understanding of how, why, and under what circumstances issues in medical ethics come to the fore and achieve national or even international prominence, as well as how some issues fade away from view only to surface again and be rediscovered by later observers (Sulmasy and Sugarman, 2010 (a)).

Understanding the historical perspective in the context of mental health is essential as this allows for an understanding of why mental health care has been reduced to a "Cinderella" discipline and also how societal attitudes and perceptions have been negatively shaped and perpetuated in this regard. A critical analysis of the phases of historical psychiatric development and its associated vulnerability which have influenced psychiatric services and mental health law in South Africa is provided. The chapter responds directly to objectives 1 and 3.

3.1. Phase 1: The Period of Expediency and Restraint (17th – 18th century)

Degrading and unethical treatment of people with mental health conditions dates prior to the 17th century and has been rooted in various religious, social, and cultural beliefs. For example, the belief that demonic possession caused mental ill health, which during this period, was referred to as 'insanity'. As a result, it was argued that to protect the broader society, people with mental illnesses were to be isolated from society as supported by the policies and legislation in place during that time. This era of poorly justified utilitarian approaches to mental health care was referred to as the Period of Expediency and Restraint, and, as the name suggests, involved the mechanical restraint and detention of people with mental illnesses (Minde, 1974).

The historical development of psychiatry in South Africa is documented mainly from the 17th century when the Europeans colonized South Africa through the Cape Colony, which is also referred to as the Cape of Good Hope in the modern-day Western Cape (Gillis, 2012). The Cape of Good Hope was the first colony in South Africa and this monumental land became a major cornerstone for global slave trade and modern-day socio-economic inequality in South Africa. The introduction of psychiatry to South Africa is connected with the establishment of the Slave Trade in South Africa. South Africa had been under Dutch (Boer) and British colonisation periodically from the 17th to the late 20th century (Gillis, 2012). The Dutch East India Company was notorious for the slave trade of black people and other persons of colour brought to South Africa from various countries such as India, Indonesia, East African countries, Mauritius, and Madagascar (Gillis, 2012).

From 1674, the Dutch East India Company built institutions in the former Cape Province which housed slaves and people with mental illnesses, who were identified with terms such as 'mad' and 'lunatic' (Gillis, 2012). The accommodation as built by the Dutch was an extremely poor attempt to address mental ill-health in South Africa. as they were extremely overcrowded, dark, and unsanitary. Furthermore, patients were mechanically restrained and chained to iron rings (Gillis, 2012).

3.2. Phase 2: The Psychiatric Institution Phase (19th to 20th century)

During the period between 1795 and 1806, the Cape was temporarily occupied by the British colonial government (Minde, 1974). Before the British colonised South Africa, there was no civilian hospital in the Cape which prompted the establishment of Zeemans hospital in 1818 which was later renamed Somerset Hospital in honour of the Governor at the time (Minde, 1973). Somerset Hospital, the Old Slave Lodge, and Robben Island are some of the most significant institutions in the context of mental health. This period marked the second phase of psychiatric development in South Africa, also known as the Psychiatric Institution Phase (Gillis, 2012).

During this period, the British colonised the Cape and Natal regions whereas the Boers (Afrikaners) left the Cape region after the abolition of slave trade to colonise the Orange Free State and Transvaal (Hinds, 1985). Demographic factors, namely, gender, race, and class determined the standard of care, or lack thereof, received during these colonial times, despite contradicting liberal or enlightened philosophies and moral codes. Under colonial conditions,

authorities could place women, including white women, into long-term care just to segregate them from black men. Black 'lunatics', specifically, were viewed as inherently primitive and as a result, not eligible to access 'civilised' standards of care (Swartz, 1995).

People with mental illnesses were often subjected to peonage, forced labour, neglect, harsh institutions, deprivation of basic health care, victimization through abuse and sexual exploitation, and cruel, inhumane, or degrading treatment (Spamers, 2016). During this time, Somerset Hospital was the only facility that had beds reserved for mental health patients amongst non-mental health patients in the hospital (Makepeace, 1969). Female patients accounted for almost half the patients at Somerset Hospital, however, the first female 'lunatic nurse' was only appointed in 1832. Negative conditions prevailed with complaints of overcrowding and patients being tied up and flogged (Minde, 1974).

3.2.1. The Abolition of Slave Trade in South Africa

During slavery, HCPs in South Africa faced the inevitable moral challenge of working in a socio-politically and socio-economically nuanced system where they witnessed or contributed towards the human rights violations, namely, medical torture and civil unrest (American Association for the Advancement of Science (AAAS), 2005).

The British government in Britain passed the Abolition of Slave Trade Act on the 25th of March in 1807 that prohibited slave trade across British colonies. Today, the 25th of March commemorates the International Day of Remembrance of the Victims of Slavery and Transatlantic Slave Trade as declared by the UN (UN General Assembly, 2007). The unethical imprisonment and forceful restraint of people with mental illnesses and slaves were no longer deemed suitable as sparked by international movements in Europe, namely, the Era of Enlightenment. As a result, new institutions based on American and British models were rebuilt solely for people with mental illnesses (Carpenter, 2009).

Across most of these institutions, the socio-economic disparities between whites and persons of colour persisted with reports stating that white nurses earned almost twice as much as their counterpart-coloured nurses (Minde, 1973), whereas black people were rarely paid or not paid at all for their labour in mental institutions (Sukeri, Betancourt and Emsley, 2014). Despite the passing of the Abolition of Slave Trade Act in 1807, conditions for imprisoned patients barely improved with slavery persisting in the Cape. The situation only improved slightly in 1834 when the Slavery Abolition Act of 1833 was passed (Gillis, 2012).

Somerset Hospital could no longer cope with the overcrowding so in 1834, the medical committee of the Colonial Office turned part of the Infirm Hospital (the Old Slave Lodge) into a lunatic ward with the capacity to accommodate over 30 patients (Minde, 1974). By 1839, the management of Somerset Hospital was merged with that of the Infirm Hospital. Since the amalgamation of mental health services between these two hospitals, there have been no records of detained mental health patients at Infirm Hospital (Minde, 1974). Influenced by international movements in the mental health context, Infirm Hospital eventually discontinued the use of forceful restraint and the punishment of patients with mental illnesses who were contained in padded rooms and straitjackets. Infirm Hospital stopped providing mental health services in the early 1800s (Minde, 1974 a).

The Old Slave Lodge located in Cape Town is one of South Africa's historically significant structures that have housed people with mental illnesses since the establishment of the Dutch East India Company (Gillis, 2012). As indicated by the name, the Old Slave Lodge eventually became a hospital for emancipated slaves (Minde, 1974). After the annexure of the Cape Province by the British colonial government, the Old Slave Lodge was converted into Government Offices. During this time, an influx of psychiatric institutions was built across the Cape regions, which since 1994, has been divided into the Eastern Cape, Northern Cape, and Western Cape (Gillis, 2012).

The development of psychiatry in South Africa has also been affected by other laws under colonialism that prohibited the movement of people of colour around the country and limited their access to quality social services (Sukeri, Betancourt and Emsely, 2014). Since this time, the quality of and access to mental health care services were disproportionately influenced by prejudiced socio-political perspectives and socio-cultural stigma.

The passing of the Slavery Abolition Act of 1833 had a paradoxical effect on the socio-economic and mental health dynamics of the country. Dating back to the colonisation of the Cape and the historical development of psychiatry, South Africa's growing economy has depended heavily, if not solely, on the labour of enslaved populations (Gillis, 2012). Thus, freedom and dignified emancipation of slaves would equate to a collapse in the economic structure at the time.

3.3. The Expansion of Psychiatric Services and its influence on Historical Mental Health Laws

South African mental health law has been influenced by social, medical, political, and legislative developments in the international context, namely, colonialism, the Era of Enlightenment, Eugenics, and the Mental Hygiene Movement (Ure, 2009). A legal system defines and governs laws and rules amongst communities and societies (Edwards, 1996). As opposed to a fixed and perpetual system, legal systems ought to be viewed as dynamic systems that evolve with socio-cultural and socio-political contexts. Hence, legal science is also referred to as social and normative science (Roos, 2014). Furthermore, legal systems have been viewed as cultural products of a community, which results from its socio-political history. Similarly, in the study and critique of South African law, it is pertinent to understand the historical intersections that influenced, and to a large extent, still, influence South Africa's current legal system.

3.3.1. Lunacy Laws governing the Cape Colony.

During the Psychiatric Institution Phase, a series of Lunacy Laws were passed in the Cape Colony to deal with the protection of the property of the 'insane'. However, these laws, referred to as Ordinances, did not provide any interpretation nor guidance surrounding mental health care provision (Sukeri, Betancourt and Emsley, 2014). Ordinance No. 5 of 1833 was the earliest Lunacy Law that was concerned with the property of 'lunatics'. This law was later amended by Ordinance No. 3 of 1837 then again with Lunacy Act No. 20 of 1879 which was concerned with the 'safe custody of persons dangerously insane' and 'care and custody of persons of the unsound mind', respectively (Minde, 1973). Unsurprisingly, Act No. 20 of 1879 was deemed unacceptable leading to the promulgation of the Lunacy Act No. 35 of 1891. This new act comprised 6 sections which were concerned with the administration of a 'lunatics' property, the legal proceedings and provisions of the restraint and detention of 'lunatics', and criminality (Minde, 1974).

From 1845, policy required all mental patients to be housed in Robben Island which opened a mental section in 1846 (Minde, 1974). Robben Island is located in Table Bay, a few kilometres from the city of Cape Town, and is currently listed as a United Nations Educational, Scientific and Cultural Organization (UNESCO) World Heritage Site (Pike, 2015). The Robben Island Lunatic Asylum became the first mental hospital formally

established in South Africa even though the mentally ill patients were forced into hard labour often having to work 14-hour days (Minde, 1974). Moreover, the standard of mental health care was deficient, and the treatment of mental illnesses was influenced by prejudiced public perceptions of symptomatic factors.

Robben Island had a long history with housing 'lepers' and 'lunatics' during the Psychiatric Institution phase and later when it was used as a convict station for political prisoners (Gillis, 2012). Meanwhile, on the mainland, the New Somerset Hospital was opened in 1862 to replace the previous one which had outlived its mandate as a general hospital. The old Somerset Hospital remained as a sick home for the chronically ill up to the 1930s despite being notorious for many ground-breaking scandals in Cape Town. During this time, the old Somerset hospital did not house any patients requiring acute mental health care (Minde, 1974).

The Lunacy Act of 1845 was considered an enlightened approach to eradicating medical dominance across state asylum systems and an attempt at mitigating against the consequences of Carpenter, 2009). However, despite this so-called enlightenment, strict medical paternalism continued to infringe upon the rights of people with mental illnesses. In the context of mental health, enlightened policies did not and still do not guarantee the humane treatment of institutionalized patients, particularly in resource-deprived contexts such as South Africa (Plug and Roos, 1992; Atilola, 2016).

3.3.2. Administration of Psychiatric Services under the Lunacy Laws

Psychiatric services in South Africa formally expanded around 1872 simultaneously with the discovery of diamonds in South Africa (Minde, 1974). Soon after, asylum management became more explicit with classifying and separating patients by their race and social class (Swartz, 1995). Mental health care based on race and class has been an ongoing theme in South Africa's mental health context. Under the ever-changing Lunacy Laws and other segregationist policies during this time, various psychiatric institutions and services emerged and expanded across South Africa.

In 1857, prior to the formal expansion of psychiatric services in South Africa, the Albany Hospital in Grahamstown was opened to treat the mentally ill and chronically sick (Sukeri, Betancourt and Emsley, 2014). Most mental health institutions, particularly in the Eastern

Cape were former prisons and military camps. The Grahamstown Lunatic Asylum, which is now known as Fort England Hospital, and the Kowie Hospital, also known as Port Alfred Asylum, were opened in 1876 and 1888, respectively. These institutions were intended to serve the needs of both black and white patients. However, in 1908, the Grahamstown asylum was converted into a whites-only institution (Swartz, 1995). The infrastructure at Port Alfred Asylum was not suitable for housing patients as deemed by the 1913 Parliamentary Select Committee on the Treatment of Lunatics. The Committee recommended that Port Alfred Asylum be closed down due to its poor infrastructure and sanitation, but this was blatantly ignored as it continued to admit black patients from overflowing institutions (Minde, 1974).

In 1891, Valkenberg Hospital was built in the Western Cape for white patients, while black patients were sent to Fort Beaufort in the Eastern Cape. Fort Beaufort was opened in 1894 as the first blacks-only asylum. TB was a serious problem at this institution accounting for over half the mortality rates from 1916 to 1919. Black patients across these institutions experienced differential unethical treatment, such as being housed in cheap hut accommodations. Just as the Port Alfred Asylum, the 1913 Select Committee deemed Fort Beaufort Asylum unsuitable accommodation for mental health patients (Minde, 1974). Boundaries put in place in the Eastern Cape disproportionately affected black people's access to mental health care services since most black people were populated within that region (Sukeri, Betancourt and Emsley, 2014).

The conditions in which black people had to endure within the asylums in the Eastern Cape were inhumane, to say the least, and severely contrasted the conditions experienced by their white counterparts at Valkenberg, where patients had more liberal provision in terms of accessing basic human rights (Swartz, 1995). The farm on which the Valkenberg Hospital was built was intended to be used as a correctional facility. In the present day, Valkenberg serves as the main psychiatric hospital in the Cape Peninsula, the major referral specialist facility in the Western Cape province as well as one of the main teaching hospitals for the psychiatry department of the University of Cape Town (Swartz, 1995; University of Cape Town, 2020).

Meanwhile, in the then Transvaal, the Pretoria Lunatic Asylum was opened in 1892 which today is known today as Weskoppies (Gillis, 2012). The laws governing this Boer-oriented asylum differed vastly from asylums in the Cape. The governing 'Artikels' in Boer health law aimed to hold HCPs accountable for their negative and unethical actions towards mental

health patients (Makepeace, 1969). However, despite the so-called enlightened legal approach applied in the then Transvaal, conditions for mental health care patients were subjected to conditions shockingly similar to the conditions described in the Cape region (Plug and Roos, 1992).

3.3.3. The Mental Disorders and Defective Persons Act 38 of 1916

Increasing and conflicting colonial interests over the lives and land of black people eventually led to the Anglo-Boer war of 1899-1902. In 1910, it was decided that the four territories or provinces, namely, Cape of Good Hope, Orange Free State, Transvaal, and Natal, would converge to form the Union of South Africa (Minde, 1974). The administration of the country became the full responsibility of local white populations in South Africa restricting black people from participating in economic and political matters (Minde, 1974).

Under the new Union of South Africa, the Mental Disorders Act and Defective Persons Act No. 38 of 1916 (hereafter the Mental Disorders Act) was promulgated by the National Council for the Mental Hygiene and Care for the Feebleminded for the Union of South Africa replacing the former Lunacy Laws (Ure, 2009; Gillis, 2012). The Mental Disorders Act introduced uniformity across all provinces in the administration and regulation of mental health services. This new act abolished the controversial distinction between dangerous 'lunatics' from 'lunatics' who were not dangerous. Furthermore, the Mental Disorders Act No. 38 of 1916 made provisions for inter-state (provincial) admissions and outlined restrictions on the use of mechanical restraint on patients (Minde, 1974).

The Mental Disorders Act of 1916 was the first of many unsuccessful legislative attempts to cater to people with mental health problems in the unified South Africa (Spamers, 2016). Despite the unification of mental health institutions, mental health records during that period reflected a segregationist environment that used derogatory classifications in distinguishing the quality of care among 'lunatics'. These classifications were mainly based on the individual's gender, race, and social class (Swartz, 1995). By 1916, all white mental patients had been removed from the Robben Island Lunatic Asylum, thus, leaving behind black people and other people of colour (Minde, 1974). By 1916, all white mental patients had been removed from the Robben Island Lunatic Asylum, thus, leaving behind black people and other people of colour (Minde, 1974). Under the Commissioner of Mental Hygiene, this act

unified the control of mental institutions, which were experiencing an influx of mentally ill patients, and which focused on custodial care (Spamers, 2016).

In 1922, Komani Hospital in Queenstown was opened as the first modern mental health hospital designed specifically for mental health care not linked to convict stations nor military camps. The conditions at this mental health hospital pleasantly contrasted the conditions described in surrounding institutions but blacks and whites were still housed separately (Sukeri, Betancourt and Emsley, 2014). During the 1950s, 'Friends of Komani' was established as a community society engaging white mental health patients in the Cape with the outside world. Community reintegration had an enormous benefit on the environment of the mental health facility and the patient's well-being (Minde, 1974). However, this community psychiatric service was available only for the white and coloured populations in the region, excluding blacks from beneficial mental health services.

The Mental Disorders Act reflected the dangerous discriminatory opinions against black people and people with mental illnesses which were shared and validated as science by prominent authoritative figures and institutions in society. Although the terms and distinctions of race were not explicitly expressed in the act, they were strongly reinforced by the socio-economic and socio-political nuances. For example, a feeble-minded person under Class V of the act was defined as a person born feeble-minded by nature who is unable to compete equally with their normal counterparts. Under this act, persons of this nature ought to be removed from society (Ure, 2009). In context, such a person equated to a black person or person of colour.

In 1936, mental hygiene and eugenic ideologies were formalised through the 1936 department committee decision to segregate social services, namely health and education, by race and class (Ure, 2009). Racialised medicine was largely grounded on eugenic practices and inseparable from the historical development of psychiatry in South Africa (Ure, 2009). Alcoholism has been classified as a mental disorder by the DSM which has been rife in both white and black communities. Despite this, a greater proportion of black men were admitted into long-term custodial care. A Tower House report indicated terms exceeding 45 years of custodial care. This was supported and legally reinforced through the Prison and Reformatories Act No 13 of 1911 which provided for the admission to mental health institutions based on social grounds, i.e., racial and classist, sidelining the HCP from the

mental health process (Ure, 2009). This was a legal euphemism allowing the unlawful arrest of black and poor people.

Apartheid also had detrimental effects on mental health as it was equally discriminatory and segregationist in nature (Mhlauli, Salani, and Mokotedi, 2015). Apartheid was officially introduced as a policy in 1944 premised on the freedom and autonomy of all races and the social exclusion of black people (Ure, 2009). In 1952, coinciding with the release of the Diagnostic and Statistical Manual of Mental Disorders (DSM), the Black (Native) Laws Amendment Act No. 54 was enforced. This act, together with Section 29 of the 1945 Urn Areas Consolidation Act allowed for the institutionalisation of persons of colour who were found in white-designated areas. Furthermore, these institutitonalised, or rather detained, persons could only be released once the Governor-General at the time provided input (Ure, 2009).

Social stigma against socially marginalized groups was reinforced through the Mental Hygiene Movement and this act, which, unsurprisingly, focused heavily on custodial 'care' (Ure, 2009). It was only discovered years later in a report by the APA that most psychiatric findings during the time were made without a formal diagnosis, despite the emergence of the DSM in 1952 (WHO, 1983). Instead, decisions about the detention of persons with alleged mental illness came primarily from arresting police officers or magistrates (Ure, 2009). Regardless, the Mental Disorders and Defective Persons Act No. 38 of 1916 remained unchanged for 57 years until the emergence of the Mental Health Act of 1973.

3.3.4. The Mental Health Act of 1973

Successful treatment in mental health requires accurate, scientifically sound diagnostic criteria. The introduction of the DSM in 1952 presented a major shift from unreliable socio-politically grounded diagnoses to clinically justified assessments (Regier, Huhl and Kupfer, 2013). While most Euro-centric countries referred to the ICD published by the WHO, South Africa used the DSM by the APA as its primary diagnostic tool (Regier, Huhl and Kupfer, 2013). However, laws to reflect international changes in mental health in South Africa emerged almost 20 years after with the promulgation of the Mental Health Act of 1973 (Ure, 2009).

Under the Mental Health Act of 1973, the term 'mental illness' replaced former derogatory labels such as 'defects' and 'disorders. Another instrumental change was the emergence of

voluntary patients in mental health. Despite changes in semantics, the Mental Health Act of 1973 enabled the political abuse of power through psychiatric care (Ure, 2009). Throughout history, mental health treatment was characterised by long-term involuntary care, especially for black people as underscored in Chapter 5 section 5.2 of this dissertation. While psychiatric conditions improved for the white population, socially discriminatory and unethical psychiatric practices persisted for black people.

Apartheid was a major source of distress for the majority of the population and despite public international outcry, no immediate change occurred for South Africa's mental health context (Mhlauli, Salani, and Mokotedi, 2015; Ure, 2009). Instead, in 1976, the 1973 Mental Health Act was amended to allow blanket sanction against mental health care practitioners who provided information to the public about the human rights abuses in mental health to be prosecuted (Ure, 2009). This presented a blatant ethical conflict of dual loyalty, which is defined as:

> "simultaneous obligations, express or implied, to a patient and to a third party" (The International Dual Loyalty Working Group, 2002).

More than any other health care practice, psychiatry has an inherent dual loyalty, which oftentimes has been conflicting (Ure, 2009). Throughout the historical development of psychiatry, the morality of HCPs was perpetually tested as they often had to make a decision between upholding ethical responsibilities to their patients or legal obligation to the state (Ure, 2009; AAAS, 2005). In some cases, HCPs were victims of human rights violations because of conflicting moral attitudes and beliefs which had adverse effects on mental health care.

The legislation of controlled care to manipulate the human condition has been an intergenerational trait of South African governments since before the promulgation of the Lunacy Laws (Ure, 2009). Under Lunacy Laws and subsequent mental health laws leading to the Mental Health Act of 1973, mental health care practitioners often faced the dual conflict of protecting the best interests of the patients versus the broader society (Ure, 2009). However, society's laws and so-called protections at the time were determined by the same oppressive authorities that marginalized vulnerable groups to advance socio-political and socio-cultural agendas (Ure, 2009).

Just as the Mental Disorders Act, it was not necessary for the Mental Health Act to contain racial language as it was facilitated by other existing apartheid policies (Ure, 2009). During this time, of course, there existed no single source of domestic legislation addressing human rights, despite global developments. While unethical legislation was a major issue, it was not the main cause of human rights injustices in South Africa. Instead, interpretation, implementation of care, or lack thereof, and the overlapping apartheid policies all provided the platform on which human rights injustices could occur.

3.4. Fragmentation and separation of Mental Health services

Throughout South Africa's colonial history, the welfare and socio-economic interests of white and wealthy individuals in society were prioritized over the human rights of vulnerable individuals, namely, black people, females, and persons with mental illnesses. This perpetuated the criminalization of mental health, particularly during the apartheid period (Spamers, 2016). The Lunacy Laws and the Mental Disorders Act of 1916 legalized this criminalization with laws reinforcing the alienation, stigmatization, and disempowerment of people with mental illnesses in South Africa.

Racism in psychiatry, and as a result, in mental health, has been formally documented from 1854 in a report on Robben Island where practitioners stated that white insane patients or 'lepers', be kept separate from the black inmates. It is important to note that during 1835 – 1920, poor white Afrikaners were viewed in the same light as black people, highlighting the intersections between class and race in South Africa. The United Nations labelled apartheid as a crime against humanity and affirmed that it was a deep-rooted policy of racial segregation constructed to distribute political, social, economic, and military resources in the power of the white minority colonizing South Africa and South West Africa (now known as Namibia) from 1948 – 1994 (Minde, 1974; AAAS, 2005). The detrimental effects of apartheid on medicine, specifically the provision of mental health care, have been analysed in a WHO report released in 1983. The report, titled, 'Apartheid Medicine' condemned the low quality of care and the unhygienic conditions endured by black patients (AAAS, 2005).

The refusal to provide adequate and ethical mental health care for black people and females hallmarks the colonial contradictions of supposed enlightened approaches in western psychiatric practices (Sukeri, Betancourt and Emsely, 2014). Britain exported her psychiatric philosophy and practices to all her colonies including South Africa, so the link between race and class in mental health was inevitable. According to colonisers, the integration of people of different races and social class was considered detrimental to the process of regaining one's sanity and therefore deemed offensive to the white lunatics (Swartz, 1995). Segregationist policies resulted in a slippery slope of ethical injustices namely, inequitable distribution of resources in mental health, disproportionate levels of socio-economic development among races, differential treatment of mental illnesses – resulting in high morbidity and mortality rates among black patients – and slavery (Swartz, 1995).

Mental hygiene, racist and eugenic ideologies were widely supported by founders, editors and publishers of globally and locally acclaimed organisations such as the South African Medical Congress and the South African Medical Review (SAMR) who strongly believed in managing individual and social health to grow the nation's economy (Ure, 2009). The link between socio-economic development and mental health was reinforced through mental hygiene ideologies which held that science through harmful eugenic practices could cure mental 'deficiencies', which, at the time, were often associated with socio-economic failure. The highly controversial pseudoscientific approaches applied during this era resulted in gross human rights violations informed by biased mental health policies.

The provision of unethical mental health services during the historical development of psychiatry in South Africa was both racially and socio-economically motivated. The unequal treatment of black patients, by both the apartheid state and some of the HCPs working during that time, was rooted mainly in economic discrepancies justified by inherently skewed utilitarian arguments, i.e., for the greater good of society as demonstrated by the Smith-Mitchell and Life Esidimeni tragedies (Ure, 2009; Dhai, 2018).

The environment in which black people had to endure during colonial South Africa, to a large extent, predetermined their socio-economic development, or lack thereof. As a result, factors influencing mental health expanded to include unemployment, which was referred to as mental deficiency at the time (Ure, 2009). As most black people at the time were socio-economically disadvantaged, classism became the new racism despite the abolition of apartheid in 1994. Just as with racism, classism created a polarizing duality in the provision of

and access to essential social services. In today's somewhat post-colonial context, there are still major disparities between the mental health, legal and socio-economic systems. It can therefore be argued that racial colonial psychiatry, or apartheid medicine is still entrenched in the current provision of mental health care services in South Africa (AAAS, 2005; Sukeri, Betancourt and Emsely, 2014).

3.5. Phase 3: Modern Psychiatry in South Africa (20th – 21st century)

Modern psychiatry, also known as the third phase of psychiatric development in South Africa was defined and developed during this period. The period saw the evolution of psychiatry and the most definitive years were supposedly from the 1930s when major therapeutic advances were made with regard to mental health diagnosis, treatment, services, and outcomes (Gillis, 2012). The evolution from colonial psychiatry to modern psychiatry has been influenced heavily by the changing mental health laws in South Africa. As a result, the term 'psychiatric' became dominantly used, almost completely replacing the term 'mental'. Although not progressively, mental health policies also evolved during this time.

Therapeutic advances became widespread during this period. However, clinical advancements were augmented by the unethical and inhumane treatment of mental healthcare patients and involuntary research participants (Rich, 2015; Gillis, 2012). Over time, increased understanding of biochemical interactions with psychological processes began to improve therapeutic research and outcomes. For example, in 1949 Lithium was found to be effective in treating bipolar disorder and in 1958 it was discovered that Imipramine can treat depression, anxiety, and panic disorders (Gillis, 2012). It is important to note that most of these therapies only treat but rarely cure mental illnesses.

When the Second World War came to an end in 1945, the language in mental health began to evolve in South Africa and 'insane' and 'lunatic' became replaced with the term 'psychiatric'. In 1946, after the closing of nearly 135 military psychiatric hospitals and two years before the implementation of the apartheid policy, Tara Psychiatric Hospital established itself as the first independent psychiatric hospital under the authority of provincial health services (Gillis, 2012).

In 1949, the South African Medical Council initiated the first academic psychiatric training as a diploma at the University of the Witwatersrand (Wits), although discontinued shortly after. During the 1950s, increased awareness and acceptance of psychiatry as a major medical

discipline resulted in the establishment of psychiatric academic departments in South African universities and hospitals (Gillis, 2012). Psychiatric nurses, who formed the backbone of psychiatry, achieved their qualification under the authority of the SANC. The psychiatric course too was discontinued in the 1960s (Gillis, 2012).

The 1960s came with major academic advancements for psychiatry. In 1961, the College of Psychiatry in the Colleges of Medicine of South Africa (formerly known as the Faculty of Psychiatry in the Colleges of Medicine of South Africa) was recognised as the only exit qualification by the Health Professions Council of South Africa (HPCSA) for formal psychiatric registration (Gillis, 2012). In 1962, the Society of Psychiatrists in South Africa was established. SASOP was an independent entity that maintained high ethical standards despite South Africa's colonial context. This society of psychiatrists, neurologists and neurosurgeons was operated under and was committed to the ethical standards outlined in the Declaration of Hawaii (1977), Declaration of Tokyo (1975), and the Declaration of Helsinki (1964) (Gillis, 2012).

Leading to the 1990s, psychiatric hospitals slightly evolved to include a therapeutic team approach, social and community services, occupational therapy, and rehabilitation. By 1987, psychiatric services and responsibilities were transferred to the provincial government as opposed to the previous structure under the Nationalist Apartheid government (Gillis, 2012). The shift from national to provincial health care administration was significant in the context of Apartheid because provincial institutions were less socio-politically vested. However, phasing out of psychiatric hospitals was mostly unsuccessful in the South African context due to poor social support and under-developed community services, particularly for black communities. Provision of adequate mental health or psychiatric services was not stunted by the discipline per se, but rather by the infused social and political ideologies disproportionately affecting mental health policy and resource distribution.

3.6. Conclusion

Since the historical development of psychiatry in South Africa, people of colour, particularly black Africans, have been socio-culturally and socio-economically disenfranchised. Mental health legislation and policies during the historical development of psychiatric in South Africa were deeply entrenched in segregationist and inequitable colonial concepts. This has resulted in horrific human rights tragedies, namely, the colonisation of indigenous African practices,

slavery, apartheid, poverty, rape, and crime have had deleterious effects on the mental health of disenfranchised populations in South Africa (Mhlauli, Salani, and Mokotedi, 2015; AAAS, 2005). Despite the unification of South Africa, segregationist laws and discriminatory socio-political agendas continued to infringe upon the socio-economic, socio-cultural, and civil rights of many MHCUs and mentally ill patients.

Chapter 4: Human Rights, Health Law and Bioethical Protections in Mental Health

Bioethics has made major strides in the development of international human rights frameworks. However, it is important to distinguish and understand the relationship between ethics and law – while the two concepts are strongly related, they are not synonymous. In many countries, ethical concepts and principles are enshrined in international law (Dhai and McQuoid-Mason, 2011). To adapt to the dynamic context of health, bioethical and human rights frameworks require ongoing revision as they are the principal frameworks that provide a robust guide to addressing moral conflicts in the healthcare context (Sugarman and Sulmasy, 2010). In response to objective 2, this chapter underscores the development and evolution of international human rights and bioethical instruments and their application to mental health, as illustrated in Table 1 of this chapter.

4.1. The development of International Human Rights Law

International human rights instruments are key in the protection of human rights. Human rights frameworks are intended to protect the human rights of everyone in society, including people with mental health conditions (Spamers, 2016). During the 20th century, the progressive realisation of the right to dignity, health, and other fundamental human and socio-economic rights became an international priority (WHO, 2005). Progressive realisation refers to the obligation of the state towards the full realisation of economic, social, and cultural rights within the member states' available resources (Office of the United Nations High Commissioner for Human Rights (OHCHR), 2008).

Despite its failure to link health human rights, the United Nations Charter (hereafter the UN Charter) of 1945 is recognized as one of the most important legal instruments as it laid the foundation for universal human rights and the development of international law (Section27, 2007). Furthermore, the UN Charter comprises the UN framework which outlines the legally binding obligations of member parties towards the promotion of universal human rights. Member party governments have the legal and moral obligation to respect, protect and fulfill economic, social, and cultural human rights (OHCHR, 2008).

For governments or states to respect human rights, they ought to refrain from the interruption of those rights. For governments to protect human rights, they ought to prevent others from interrupting the full enjoyment of human rights. Moreover, for governments or states to fulfill their obligation to human rights, they ought to adopt and implement the appropriate steps towards this realisation (OHCHR, 2008). In 1946, the United Nations Commission on Human Rights (OHCHR) was established. Subsequently, in 1947, the UN established the International Law Commission to develop and structure international law (Ferreira and Ferreira-Snyman, 2014).

The UN established the International Court of Justice, known as the World Court, to settle international disputes, including disputes with socio-economic rights. The International Court of Justice is independent of the International Criminal Court (ICC) in both functional and legal capacities. However, the International Court of Justice has been in cooperation with the ICC through a Negotiated Relationship Agreement, facilitated by the UN Security Council (UN, 2020).

The United Nations Human Rights Council (UNHRC) was formed on 15 March 2006 by a UN General Assembly as an inter-governmental body mandated by the UN to strengthen, promote and protect international human rights through providing recommendations. The UNHRC replaced the former 1946 United Nations Commission on Human Rights (UN, 2020). The development of these departmental bodies was essential for the monitoring and evaluation of global human rights instruments. Binding and non-binding international ethical and legal instruments can be used as an effective tool to mitigate human rights-related issues and, in turn, implement and improve access to and provision of healthcare.

4.1.1. Customary, Hard and Soft International Health laws in Mental Health

International Law is categorized into three components, namely, Customary Law, Hard Law, and Soft Law. (Dhai, 2011). Customary Law, which is separate from domestic Traditional Customary law, is based on agreed-upon universal principles that are internationally binding despite ratification status (Section27, 2007). Customary international law is comprised of legal principles and therefore it is widely accepted by governments as legally binding. Most international human rights frameworks constitute customary law (Spamers, 2016).

Hard Law exists as legally binding bilateral or multilateral formal agreements between nations defining duties towards citizens and/or between nations. These agreements include

Treaty Law, Conventions, Covenants, and Charters. Through a formal signing process which is followed by a ratification process, states become member parties and therefore become legally obligated to uphold principles and laws enshrined within these agreements, (Section27, 2007).

In contrast, Soft law refers to non-binding guidelines by international non-governmental organisations (NGOs) and declarations by international bodies. Bioethical guidelines are often categorized under soft law. Although not legally binding, these guidelines and policy declarations set the standards of conduct across various industries and have made major strides in healthcare practice and research ethics (Section27, 2007).

With the inclusion of civil society and government bodies, decisions leading to international law frameworks are undertaken by major stakeholders in the health context, including the United Nations (UN), the World Health Organizations (WHO), World Medical Association (WMA), and World Psychiatric Association (WPA), who all set the international standard for global health and influence developmental and humanitarian agendas. (Section27, 2007). Thus, governments have a legal and moral obligation to enforce international customary, hard, and soft human rights laws into their domestic contexts. The section that follows outlines hard, customary, and soft laws that pertain to the protection of mental health and their ratification status in South Africa.

4.1.2. The right to health

The right to health and, in turn, to access healthcare, is echoed in almost all bioethical and human rights instruments. International law and human-rights frameworks are essential in the context of mental health because they are the only legal instruments that justify the international scrutiny of mental health policies and practices within a sovereign country. Furthermore, these international instruments enshrine fundamental protections and freedoms that should surpass any political process (Spamers, 2016). The International Bill of Rights comprises the Universal Declaration of Human Rights (UDHR) the International Covenant on Economic, Social and Cultural Rights (ICESCR), and the International Covenant on Civil and Political Rights (ICCPR) (Ferlito and Dhai, 2017). The ICESCR expresses the attainment of the highest attainable standard of health and reaffirms the right to health as a socio-economic right.

The right to access mental health services entails services that are available, acceptable, and appropriate or of good quality. Access, acceptability, availability, and quality have been deemed necessary factors for any nation's health system by the Committee on Economic, Social and Cultural Rights (CESCR) (OHCHR, 2000; Dhai, Gardner and Mahomed, 2021). In the context of mental health, this includes access to rehabilitation services and individualized treatment that promotes autonomy, social integration, and social justice, particularly through community-based services. In the extreme case that a right must be restricted or limited, the principle of proportionality may require governments to invoke judicial safeguards, for example, a hearing or guaranteeing independent and impartial decision-making (Rosenthal and Sundram, 2004).

When the United Nations adopted the UDHR in 1948, exactly three years post the Second World War, sovereign African countries that participated in this activity were few. The UDHR, therefore, reflected one of the greatest political paradoxes in history. UN members who were the biggest supporters of this declaration, namely Belgium, France, Great Britain, Portugal, and Spain, were still in possession of many colonies in Africa often lacking any accountability for their contributions to the international human rights discourse (Kuwonu, 2019). Colonialism has been a human rights tragedy, because most, if not all, indigenous inhabitants of these colonies were stripped of their basic human rights, enslaved, and subjected to traumatizing conditions as opposed to being treated as dignified human beings.

Dignity has been guaranteed and is enshrined in the UDHR and various international instruments, yet this human right has been severely suppressed, specifically in the context of mental health. The UN, and related agencies, have provided an abundance of laws and frameworks to address growing concerns in the mental health context in addition to tools aimed at advancing the human rights and bioethical protections of persons with poor mental health conditions (Kuwonu, 2019). Governments that have ratified international human rights conventions have a legal and moral obligation to take necessary steps within their constitutional provisions to adopt these rights and report back on the steps taken to implement adopted policies.

4.1.2.1. The right to dignity is indispensable to the right to health.

The human right to dignity is expressed in most international human rights instruments. As underscored throughout this dissertation, dignity is indispensable to the provision of healthcare, specifically mental health care, and is expressed in the UDHR. The right to health,

which informs the right to access healthcare, was first expressed in the UDHR. The UDHR is the most translated document in the world and is arguably the most important framework in the history of human rights and socio-economic development. As a result, the UDHR has been applied across all disciplines. Dignity is identified as the foundation of global human values such as freedom, justice, and peace. Article 1 of the UDHR stipulates:

> "All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood" (UN General Assembly, 1948).

From a normative ethical perspective, reason has been described as the capacity of an individual to process logical inferences and justify beliefs and decision-making processes based on existing information (Neuroscience Research Australia, 2020). In a socio-culturally nuanced and socio-politically biased society, existing information has not always been reliable. Good and inherently ethical normative frameworks are often tarnished by biased and discriminatory socio-cultural perspectives that have had detrimental consequences for individual dignity and socio-economic development. Specifically, the capabilities of vulnerable individuals have often been limited as a result of oppressive and restrictive socio-cultural policies and practices as witnessed during South Africa's Mental Hygiene Movement where it was thought that black people were intellectually and mentally inferior to white people.

As mentioned in Chapter 1, section 1.1.5, Principlism: Bioethical Framework for Mental Health, dignity is indispensable to the principle of autonomy, which is grounded in the right to self-determination and liberty. The methods associated with the historical development of psychiatry, namely involuntary admission of patients into psychiatric institutions and the forceful participation of individuals in unconsented unethical clinical practices, contradict basic human rights, namely the right to freedom and autonomy (Ure, 2009).

4.1.3. Vienna Convention on the Law of Treaties (VCLT)

International law and human rights treaties and conventions often contain details for member states signing, ratifying, or acceding to them. The process of signing and ratifying a treaty has the same effect as acceding to a treaty. Most treaties are restricted to member states, for example, member states of the United Nations or member states of the Statute of the International Court of Justice (Ferreira and Ferreira-Snyman, 2014). Article 81 of the Vienna

Convention on the Law of Treaties (VCLT or the Vienna Declaration) outlines this type of entry-into-force clause whereas some treaties are open to all states willing to accept the provisions enshrined (Ferreira and Ferreira-Snyman, 2014).

The Vienna Convention on the Law of Treaties (VCLT) was adopted by the UN as the 'treaty of treaties' as customary international law which provides comprehensive guidelines, rules, and procedures on the interpretation of UN treaties and laws (The World Conference on Human Right, 1993). The Vienna Convention was opened for signature in 1969 but only came into force in 1980 (UN Treaty Collection, 2020).

Article 24 of the VCLT outlines States' obligation to implement adequate and sustainable measures to address social inclusion and promote the rights of vulnerable and marginalised groups (The World Conference on Human Rights, 1993). Furthermore, to protect the international human rights law of all individuals, Article 27 of the Vienna Convention on the Laws of Treaties prohibits countries from evading treaty obligations under the auspices of domestic law (World Conference on Human Rights, 1993).

4.1.4. Normative Frameworks on Mental Health and Disability

The United Nations Convention on the Rights of Persons with Disabilities (CRPD) was promulgated in 2008 with its Optional Protocol as the first legally binding human rights instrument of the 21st century. Sources of international hard law underscore already existing human rights in international customary law and outline specific safeguards for mental health concerns with an increased focus on the obligations of state parties which ought to promote and protect the human rights of persons with disabilities (UN, 2008).

The biological underpinnings and social implications of autonomy in the context of mental health have placed severe limitations on the universal human right to dignity. The Preamble of the Convention recognizes the importance of autonomy and justice in the achievement of equal human rights. Autonomy includes the freedom of persons with mental illnesses and disabilities to make their own choices, more so with regard to their health and accessing health care, whereas justice refers to the government's responsibility to allocate and distribute mental health resources fairly, without discrimination (UN, 2008).

John Rawls describes justice as systematic cooperation and fairness and underscores the role of citizens in a democratic society (Tandwa, 2018). Justice is premised on freedom and

equality; therefore, citizens or members of society have or ought to have moral and political powers as they have a reasonable capacity to fulfill their civil obligations and make decisions that align with what is in their best interests (Tandwa, 2018). In the context of normative frameworks, justice refers to the "fair, equitable, and appropriate treatment of all" (Rawls, 2001). The fair, equitable, and appropriate treatment of all, ought not to be applied solely in the context of distributive justice of resources, but ought to be reflected in social policies as well (Rawls, 2001; Tandwa, 2018). Therefore, all citizens ought to have the fair opportunity to participate in normative frameworks, particularly those affecting their human and socio-economic rights (Tandwa, 2018). Fair opportunity underscores the need for equality and universal inclusion without discrimination of socio-economic status (Tandwa, 2018).

However, in the context of mental health, equality cannot be realised merely through the guarantee of equal rights, nor the prohibition of discrimination as enshrined in the CRPD. In addition to combating discriminatory stereotypes that impede the right to access health, it is imperative to address socio-economic vulnerabilities through increased opportunities for persons with disabilities (Goldschmidt, 2017).

For an individual to thrive and take full advantage of their capabilities, dignity ought to be operationalized through the realisation of other tangible human rights, namely, socio-economic development, as argued by Amartya Sen (Sen, 1990). The adoption and ratification of the CRPD have provided the international community with a strong normative framework on disability therefore the CRPD should serve as a rights-based approach to mental health that acknowledges the intrinsic relationship between the right to dignity, mental health, and socio-economic development (Spamers, 2016).

Table 1: International Human Rights and Bioethical Instruments influencing Mental Health Protections

A number of international human rights and bioethics instruments have an influence on mental health. The table below illustrates normative instruments provided by international and regional agencies, their status in South Africa as well as the mental health protection they provide.

Name of Instrument International Ratification	**Agency** Type of Framework	**Ratification status in South Africa**	**Mental Health Rights and Protection(s)**
Constitution of the World Health Organization **Adopted:** 19 June 1946 **Signed:** 22 July 1946 **Entry into force:** 7 April 1948	**World Health Organization (WHO)** Customary Law	**Signed:** 22 July 1946 **Ratified:** 7 August 1947	- **Article 1**: Objective to attain the highest possible level of health for everyone. - **Article 2:** WHO will function to: - (c) to assist Governments, upon request, in strengthening health services.
The Universal Declaration of Human Rights (UDHR) **Entry into force:** 10 December 1948	**United Nations (UN)** Initially adopted as soft law and later hardened into Customary law.	Union of South Africa Abstained. Not ratified However: UDHR is still enforceable in South Africa as customary international law applies to all member states.	- **Article 1:** Right to equality and dignity of humans bestowed with reason and conscience. Spirit of brotherhood - **Article 3**: Right to life, liberty, and security - **Article 4**: Prohibition of slavery, servitude, and slave trade - **Article 5**: Protection from torture, cruel or inhumane treatment - **Article 6**: Right to recognition everywhere as a person before the law - **Article 7**: Equal rights of all humans before the law and protection from discrimination in violation of Declarations rights - **Article 21:** Equal access to public service - **Article 22**: Economic, social, and cultural rights as indispensable for dignity and free development of individual - **Article 25**: Right to a standard of living suitable for health and well-being despite circumstances in livelihood.
Declaration of Helsinki Ethical Principles for Medical Research involving Human Subjects. **Adopted:** June 1964	**World Medical Association (WMA)** Soft law / Ethical Guideline	**Adopted:** October 1996 at the 48th WMA General Assembly at Somerset West	- **Principle 2:** Physician duty to safeguard health of society. - **Principle 9:** Awareness of and adherence to ethical regulatory research guidelines. - **Principle 10:** Physician duty to protect life, health, privacy, and dignity of research participant.

Declaration on the Rights of Mentally Retarded Persons* **Adopted:** 20 December 1971	**United Nations (UN)** Soft law / Guideline	Not Applicable.	- **Principle 1:** Equal human rights to the maximum degree of feasibility - **Principle 2**: Right to proper medical care, physical training, education, and rehabilitation to develop maximum potential. - **Principle 3**: Right to a decent standard of living and economic security to reach full capabilities. - **Principle 4**: Right to community life through adequate integration - **Principle 5**: Right to qualified guardian required to safeguard the well-being and best interests. - **Principle 6**: Protection from abuse, exploitation, and other degrading treatment. - **Principle 7**: Right to legal safeguards.
Declaration of Tokyo Guidelines for Physicians Concerning Torture and other Cruel, Inhuman or Degrading Treatment or Punishment in Relation to Detention and Imprisonment **Adopted**: October 1975	**World Psychiatric Association (WPA)** Soft law / Ethical Guidance	Not Applicable.	**Preamble:** - The physician ought to practice medicine in the service of humanity and to restore and preserve bodily and mental health. - Torture is defined as the deliberate and systematic, infliction of physical or mental suffering by authoritative figures.
Declaration on the Rights of Disabled Persons **Adopted:** 9 December 1975	**United Nations (UN)** Soft law / Principle Framework	Not Applicable.	- **Principle 1**: Inclusion of deficient mental capabilities in the definition of disability - **Principle 2**: Non-discrimination and equality - **Principle 3**: Inherent respect for dignity - **Principle 4**: Equal civil and political rights - **Principle 5**: Right to self-reliance support - **Principle 6**: Right to medical and psychological treatment that allows adequate integration or reintegration into society. - **Principle 8**: Consideration of special needs of disabled persons in socio-economic development - **Principle 9**: Right to live with family. Disabled persons requiring specialised treatment are entitled to a decent living environment.

			- **Principle 10**: Protection from discriminatory and degrading treatment
International Convention on the Suppression and Punishment of the Crime of Apartheid **Adopted:** 18 July 1976	**United Nations (UN)** Customary Law	South Africa was ¼ of countries voted against its adoption	All articles applicable to mental health considering the psychological distress associated with the apartheid policy.
The International Covenant on Economic, Social and Cultural Rights (ICESCR) **Adopted:** 16 December 1966 **Entry into force:** 3 January 1976	**United Nations (UN)** Hard law	**Signed:** 3 October 1994 **Ratified:** 12 January 2015	- **Preamble**: All the rights enshrined recognise the inherent dignity of the human person - **Article 1**: Right to self-determination in pursuit of economic, social, and cultural development - **Article 12**: (1): The right of every individual to enjoy the highest attainable standard of physical and mental health. (2)- State obligation to recognize rights enshrined in Covenant including, but not limited to, the improvement of health and hygiene conditions.
The International Covenant on Civil and Political Rights (ICCPR) **Adopted:** 16 December 1966 **Entry into force:** 23 March 1976	**United Nations (UN)** Hard law	**Signed:** 3 October 1994 **Ratified:** 10 December 1998	- **Article 1**: Right to self-determination in pursuit of economic, social, and cultural development. - **Article 6**: Inherent right to life - **Article 7**: Protection from torture, cruel, inhumane, and degrading treatment or punishment including unconsented scientific/medical procedures. - **Article 9**: The right to security of the person - **Article 16**: Equal recognition before the law for all persons.
Declaration of Hawaii **Adopted:** August 1977	**World Psychiatric Association (WPA)**	Not Applicable.	- **Article 1**: Aim of Psychiatry to promote health, personal autonomy, and growth. Grounded in principles of best interest and distributive justice.

	Soft law / Ethical Guidelines	Emerged because of political misuse of psychiatry in South Africa, Romania and Soviet Union (Okasha, n.d.)	- **Article 3**; Doctor-patient relationship based on mutual trust, confidentiality, and responsibility. - **Articles 4 and 5**: Informed consent given provided capacity to consent and exercise free will. - **Article 7**: Psychiatrists to maintain professionalism and non-maleficence. - **Article 8**: Right to confidentiality - **Article 9**: Informed consent - **Article 10**: Withdrawal from treatment
Declaration of Alma-Ata **Adopted:** 12 September 1978	**International Conference on Primary Health Care (Almaty)** Soft Law / Ethical Guidance	Not Applicable.	**Declarations:** - 1. Acknowledges the role of socio-economic development for the fundamental human right to health - 4. People are entitled to and responsible for planning and implementation of their health care. - Governments responsible for adequate health and social measures. Reiterates importance of Primary health care in the spirit of social justice.
Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) **Adopted:** 18 December 1979 **Entry into force:** 3 September 1981, *in accordance with article 27(1)]*	**United Nations (UN)** Hard law	**Signed:** 29 January 1993 **Ratified:** 15 December 1995	- **Article 12:** - **(1)** – State obligation to eliminate discrimination and provide equal access to health care - **(2)** – Equality in healthcare access, including family planning services
Declaration of Lisbon on the Rights of the Patient **Adopted:** September 1981	**World Medical Association (WMA)** Soft Law / Ethical Guidance	Not Applicable.	- **Principle 1**: Right to good quality medical care, free from discrimination and is in best interest of patient. - **Principle 2**: Right to freedom of choice - **Principle 3**: Right to autonomy and self-determination. - **Principle 4**: Defines unconscious patient. - **Principle 5**: Defines the legally incompetent patient. - **Principle 6**: Procedures against patient's will.

			- **Principle 7**: The right to information. - **Principle 8**: The right to confidentiality. - **Principle 9**: The right to health education. - **Principle 10**: The right to dignity. - **Principle 11**: The right to socio-cultural support.
Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment **Entry into force:** 26 June 1987	**United Nations (UN)** Hard Law	**Signed:** 29 January 2020 **Ratified:** 10 December 1998	- **Article 1.1:** Protection from severe physical and mental pain, intimidation, and coercion
Convention on the Rights of the Child (CRC) **Adopted:** 20 November 1989 **Entry into Force:** 2 September 1990	**United Nations (UN)** Hard Law	**Signed:** 1993 **Ratified:** 16 June 1995	- **Article 3:** Promotion of child's best interest ought to be of primary concern. - **Article 6:** Recognizes every child's inherent right to life. - **Article 17:** The promotion of child's social, spiritual, and moral well-being and physical and mental health in dissemination of information - **Article 24:** The right of a child to enjoy the highest attainable standard of health and rehabilitation of health. - **2.**b. Emphasizes the development of primary health care services
Principles for the protection of persons with mental illness and the improvement of mental health care (MI Principles) **Adopted:** 17 December 1991	**United Nations (UN)** Soft Law	Not Applicable.	- **Principle 1:** Fundamental freedoms and basic rights -access to best attainable mental health care - **Principle 2:** Protection of minors - **Principle 3:** Right to community life which includes the right to live and work, as far as possible, in the community. - **Principle 4:** Determination of mental illness ought to be in line with international standards. - **Principle 5:** The right to consent to medical examination. - **Principle 6:** The right to Confidentiality - **Principle 7:** The right to community and culture - **Principle 8:** The right to appropriate standards of care

			- **Principle 9:** The right to treatment in a healthy environment - **Principle 10:** The right to quality medication prescribed by a mental health practitioner. - **Principle 11:** The right to consent to treatment. - **Principle 12:** The right to notice of rights and where capacity is lacking, to nominate legal representation to communicate the entitled rights. - **Principle 13:** The right to ethical health facilities - **Principle 14:** Mental health facilities ought to have an adequate level of resources. - **Principle 15:** Protection of persons from involuntary admission into mental health institutions unless necessary - **Principle 16:** Involuntary admission in accordance with Principle 4 where the individual has the potential to be harmed or harm others because of mental illness. - **Principle 17:** The right to an independent and impartial judicial or review body - **Principle 18:** The right to procedural safeguards - **Principle 19:** The right to access medical information. - **Principle 20:** Protection for criminal offenders determined to have a mental illness. - **Principle 21:** The right to complain through domestic procedures. - **Principle 22:** Protection from violation and right to monitoring and remedies. - **Principle 23:** The responsibility of states to actively implement necessary measures promoting mental health. - **Principle 24:** Application of MI Principles to all states and persons admitted to mental health facilities. - **Principle 25:** Protection from restriction or derogation of existing rights
Standard Rules on Equalization of Opportunities for Persons with Disabilities	**United Nations (UN)** Soft law	Not Applicable.	- **Rule 2**: Access to effective and preventative care - **Rule 3**: Rehabilitation based on full participation and equality. - **Rule 5**: Accessibility to opportunities in society - **Rule 9**: The right to family life and integrity

Adopted: 20 December 1993			- **Rule 14**: Policymaking and planning of socio-economic development - **Rule 15**: Legal safeguard to achieve goals of full participation and equality. - **Rule 20**: State obligation to implement disability programmes.
Declaration of Madrid **Adopted:** 25 August 1996	**World Psychiatric Association (WPA)** Soft law / Ethical Guidance	Not Applicable.	- **Article 3**: Mutual trust and respect to make informed decisions. - **Article 4**: Legal safeguard in place for incapacitated patients that ensures the best interests of the patient. - **Article 6**: Right to confidentiality - Right to ethical research conduct and protection of vulnerable participants.
Guidelines for Promotion of Human Rights and Persons with Mental Disorders **Adopted:** 1996	**World Health Organization (WHO)** Soft Law / Guidance document	Not Applicable.	- **Principle 1:** Exercise civic, economic, and cultural rights? - **Principles 3 and 5**: Legislation governing mental health care and quality of care? - **Principle 8:** Is standard of care and resource availability for people with mental illnesses comparable to those of physically ill persons? - **Principle 13:** Availability of essential drugs? - Protections in place to protect autonomy, confidentiality, and respect informed consent? - **Principle 23.** Are prisons or jails being used to house people with mental disorders?
Convention on the Rights of Persons with Disabilities (CRPD) [3 May 2008, in accordance with article 45(1)]	**United Nations (UN)** Hard law	**Signed:** 30 March 2007 **Ratified:** 30 November 2007	- **Article 1** – Purpose to promote, protect and realize the equal rights and inherent dignity of all persons with disabilities, including people with mental impairments. - **Article 3** – General principles, namely, inherent dignity, autonomy defined as freedom to make independent choices, equality, non-discrimination, inclusion, and accessibility. - **Article 12** – Equal recognition before the law obligating states to support persons with disabilities to enjoy their legal capacity. - **Article 13** Access to justice - **Article 17** – Physical and mental integrity of persons with disabilities - **Article 19** – Community inclusion and participation.

Declaration of Astana **Adopted:** 26 October 2018	**Global Conference on Primary Health Care** Soft Law	- **Article 2:** Affirms that strengthening Primary Health Care (PHC) as the most inclusive and efficient approach to addressing physical and mental health as well as social well-being. Emphasizes the need for equitable access to quality health care, free from financial hardship. - **Article 5:** Commits to capacity development and strengthening through PHC to manage mental health among other aspects of health.

*the term mental retardation as used by the UN's Declaration on the Rights of Mentally Retarded Persons has been said to have no scientific worth and to be socially harmful. The Diagnostic and Statistical Manual of Mental Disorders (DSM) recently replaced the term with 'intellectual disability' and more recently with 'intellectual development disorder' despite a global lack of consensus. Furthermore, the terms 'retardation' and "retarded" have been removed from the 11th edition of the International Classifications of Diseases (ICD) (Social Security Administration, 2013).

4.2. African Perspective: Regional Human Rights Laws

Monist and dualist theories assist in the clarification of the relationship between international law and domestic law. However, there is little to no guidance when it comes to the implementation of regional law into domestic law (Enabulele, 2016). Mental health care governance is a global challenge that disproportionately affects the African region. This is perpetuated by widespread economic inequalities in the African region. In addition to a public health priority, mental health has been framed as a developmental challenge that needs to be prioritized given the substantial economic costs associated with mental health care.

Despite the socio-economic challenges facing Africa, regional governance has a crucial role in supporting and strengthening mental health systems (van Rensburg and Fourie, 2016). In addition to the international instruments listed in Table 1, the regional frameworks listed in

Table 2 provide ethical and legal guidance for human rights-related injustices within Africa's mental health context.

Table 2: Regional Human Rights and Bioethical Instruments influencing Mental Health Protections in Africa

Name of Instrument Regional Ratification	**Agency** Type of Framework	**Ratification status in South Africa**	**Mental Health Rights and Protection(s)**
The African Charter on Human and People's Rights (Banjul Charter) **Adopted:** 1 June 1981 **Entry into force:** 21 October 1986 (Also known as, Africa Human Rights Day) **Last update:** 16 May 2018	**Organization of the African Unity (OAU)** Customary law	**Signed:** 9 July 1996 **Ratified:** 9 July 1996	- **Article 3:** Equality of all beings before the law - **Article 5**: Inherent dignity and recognition before the law. Prohibition of slavery and degrading treatment - **Article 6**: Right to liberty and security of person - **Article 16**: Right to the best attainable state of physical and mental health - **Article 18**: Elimination of discrimination against people with disabilities and other vulnerable individuals - **Article 20**: Right to inalienable self-determination and freedom to socio-economic development
African Charter on the Rights and Welfare of the Child **Adopted:** 1 July 1990 **Entered into force:** 29 November 1999. **Last updated:** 27 June 2019	**Organization of African Unity (OAU)** Soft / Customary Law	**Signed:** 10 October 1997 **Ratified:** 07/01/2000	- **Article 3(5):** Recognizes the respect and inherent dignity of the child. - **Article 11:** Education: Promoting mental talents of the child. - **Article 14:** Right of every child to best attainable state of physical, mental and spiritual health. - **Article 16:** Protection against child abuse, - **Article 21 (1):** Protection against Harmful Social and Cultural Practices affecting dignity and welfare of child.

Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (2003) **Adopted:** 1 July 2003 **Entry into force:** 25 November 2005 **Last update:** 17 September 2019	**African Union (AU)** Customary Law	**Signed:** 16 March 2004 **Ratified:** 17 December 2004	- **Article 16: (**c) Protect mental and physical health of woman. - **Article 23:** Special protection of women with disabilities with specific measures to improve socio-economic needs; enhance decision-making and eradicate discrimination. - **Article 24:** Special protections for women in distress reiterating right to dignity.
Protocol on Health 1999 **Adopted:** August 1999 **Entry into force:** 14 August 2004	**Southern African Development Community (SADC)** Hard law	**Signed:** 18 August 1999 **Ratified:** 7 April 2004	- **Article 4:** Commitment to Primary Health Care Services and access to health care services - **Article 15:** Disabilities: prevention, equalization of opportunities and community-based rehabilitation - **Article 20:** Traditional Health Practitioners - **Article 22:** Mental Health: Well-being essential for socio-economic development. States ought to respect the dignity of mentally ill persons and mental health and integrate primary health care into mental health.
Africa Health Strategy 2016 -2030	**African Union** Strategic Framework	Not Applicable.	**Guiding Principles:** - Strengthen health systems including mental health through a multidisciplinary approach to promote socio-economic development. - Prioritize programs to address health problems including mental health. **Vision and mission:** Reduce the burden of disease, including disability. **Objective 1:** Expanding social protections through Primary Health Care, simultaneously empowering communities. **Objective 2:** Reduce morbidity and end preventable mortality.

4.2.1. The African Union and its role in the protection of mental health rights

In 1963, almost 20 years after the adoption of the UDHR, 32 heads of independent African states convened in Addis Ababa, Ethiopia to sign the Charter forming the Organization of African Unity (OAU) (Organization of African Unity (OAU), 1986). The main purpose of the OAU was to eradicate all forms of colonialism in Africa and to promote international human rights in alignment with international human rights standards. In 1981, African Member States of the OAU convened in Nairobi, Kenya to adopt the African Charter on Humans and People's Rights. In 2005, the OAU was replaced by the African Union (AU) in Durban, South Africa (National Commissions for UNESCO, 2020)

Even though the African Charter emphasized freedom, justice, dignity and equality among other human rights principles, many Africans across the continent do not have access to even the most basic human rights and have faced intergenerational barriers to socio-economic development. The AU's new focus became to propel socio-economic growth in the African context, slightly shifting from the OAU's previous focus on decolonization to increased cooperation and integration of African states (African Union, 2019). The AU has been supported by several decision-making organs, councils, and committees to promote the participation of African citizens and civil society in accessing human rights (African Union, 2019).

Judicial and legal matters including human rights issues are handled by multiple regional organs. The African Commission on Human and Peoples' Rights (ACHPR) was inaugurated on 2 November 1987 in Addis Ababa, Ethiopia. (African Commission on Human and Peoples' Rights (ACHPR), 2020). In 1998, the African Court on Human and Peoples' Rights (AfCHPR), was created to safeguard human rights protections and came into force years later on the 25th of January 2005. Additional stakeholders in respect to regional human rights protections include African Union Commission on International Law (AUCIL), and the African Union Advisory Board on Corruption (AUABC) (African Union, 2019).

4.2.1.1. South Africa's relationship with the African Union

At the end of apartheid, South Africa ratified the African Charter which was significant because it underscored the need to address socio-economic inequities including access to health as articulated by Article 16. However, the end of apartheid and the formation of the

new democratic government in South Africa did not equate to the eradication of human rights violations (Amnesty International, 2006).

In January 2020, South Africa assumed the chair of the AU, succeeding Rwandan President Paul Kagame and Egyptian President Abdel Fattah el-Sisi who chaired the AU from January 2018 – February 2019 and February 2019 – February 2020, respectively (African Union, 2019). Member states have been bound by Article 26 which obligates states to the fulfillment of the rights and freedoms as expressed in the African Charter of Humans' and Peoples Rights (OAU, 1986).

To date, the court has delivered only one judgement in the case of human rights violations, which is shocking for a continent with the highest prevalence of human rights injustices (Du Plessis, 2020). South Africa becoming chair of the AU was significant because as chairperson, President Cyril Ramaphosa was assumed to have considerable power to accelerate socio-economic integration in Africa, to align continental and national priorities, and to strengthen the commitment towards democracy and good governance among all 53 ratified members of the African Charter (Louw-Vaudran and Diatta, 2019). However, the current state of socio-economic development and mental health in South Africa portrays a different story.

4.2.2. Southern African Development Community Protocol on Health

The Southern African Development Community (SADC) is one of the African Union's most prominent Regional Economic Communities (RECs). Recognizing that a healthy population is critical for socio-economic development, the SADC passed its Protocol on Health in 1999, five years after South Africa joined and acceded to the SADC Treaty in 1994 (Southern African Development Community, 2012). In 2005, the SADC Tribunal sub-regional court was established in Namibia, which has a deep-rooted relationship with South Africa's colonial history. The establishment of this regional court was relevant, not only for strengthening human rights protections but for enforcing protections of the human rights of individuals in the African region (Nathan, 2013).

In 2011, the Tribunal was suspended due to Zimbabwe's alleged violation of SADC regional laws as adopted by the SADC Summit (Southern African Litigation Centre, 2019). This disbandment was very unfortunate because, unlike many other international and regional frameworks, the SADC Protocol on Health provided legally binding practical steps addressing

mental health as opposed to merely mentioning it broadly under the general notion of health. Article 22 of the SADC Protocol on Health is arguably the most comprehensive article for the right to mental health and its provision. Moreover, the disbandment of the SADC Tribunal undermined the regional right to social and economic needs such as the right to health, reflecting the interplay of regional and domestic laws and politics (Nathan, 2013).

In the case of *Law Society of South Africa and others v The President of the Republic of South Africa*, former South African, President Jacob Zuma, was criticized for his participation in the disbandment of the SADC in 2011 and for signing the new SADC Tribunal in 2014 (Southern African Litigation Centre, 2019). Under the new tribunal, sub-regional disputes were limited to member states of the SADC (Phooko, 2018). In effect, the new tribunal restricted individuals living in the SADC region to seek the Tribunal for legal remedy (Southern African Litigation Centre, 2019).

The lack of functional normative integration at a regional level threatened the implementation of human rights amongst individuals in the African region (van Rensburg and Fourie, 2016). Normative integration has been described as shared values or a frame of reference between individuals and organisations. In August 2017, South Africa was chair of the SADC and during her tenure as SADC chair, South Africa managed to secure investments across various sectors including access to medicines (Republic of South Africa, 2018).

4.3. South Africa: Health Law and the Human Right to Mental Health

South Africa has one of the most robust legal systems in the world informed by the critically acclaimed Constitution. Historically, the legal system purported to oppress the rights of already marginalised populations in society. Just as the emergence of global bioethical and human rights frameworks so too evolved perceptions in the provision of healthcare. However, modern-day frameworks are not free from limitations, namely, structural, and financial resources. Oftentimes, the state has used these legislative limitations as scapegoats for unethical and borderline criminal human rights injustices, as observed with the apartheid government in the Smith-Mitchell transfers which are analysed further in chapter 5 section 5.3.1. The legal system that developed from the unification of South Africa legitimized white dominion and supremacy in the country, even though white people accounted for 20% of the national population, whereas Black, Coloured, and Indian people constituted the majority of

the population yet had little to no access to social resources and services (South African Government, n.d). While the right to health is an internationally enshrined human right, its translation and implementation vary across regions.

4.3.1. The Constitution of the Republic of South Africa

The Constitution of the Republic of South Africa (Act No. 108 of 1996) underscores the progressive realization of the right to access to health care informs the National Health Act No. 61 of 2003 (NHA) which serves as the national framework based on democratic, social justice, and human rights values (Szabo and Kaliski, 2017). This framework was intended to provide for a structured and equitable healthcare system that is cognizant of the historical socio-economic injustices that have disproportionately affected the access, quality, and distribution of health care services in South Africa (Republic of South Africa, 2004).

As mentioned in section 4.1.3. countries ought to adhere to and implement customary frameworks that promote human rights, including the right to health. Even though South Africa, technically, did not become party to the VCLT agreement, she has been bound by the provisions of the VCLT, which was automatically binding on all member states regardless of ratification status (Parliamentary Monitoring Group, 2010). The Constitution aims to mitigate historical injustices and is considered one of the most progressive domestic constitutions in the world (Melber, 2014). Most, if not all, international human rights are enshrined in South Africa's Constitution under the Bill of Rights in Chapter 2 and therefore are legally enforceable (Republic of South Africa, 1996).

The Constitution Court (CC) is the highest court presiding over constitutional and human rights injustices. In the interpretation of international law, Section 39 of the Bill of Rights, Chapter 2, expresses in the Constitution that a court, tribunal or a forum:

> "(a) must promote the values that underlie an open and democratic society based on human dignity, equality and freedom;
>
> (b) must consider international law; and
>
> (c) may consider foreign law" (Republic of South Africa, 1996)

While international law is concerned with laws that govern conduct between sovereign countries, foreign law is concerned with the domestic laws of foreign countries, therefore only

may be considered as opposed to international law which must be considered in the interpretation of domestic law (Law Library of Congress, 2010). According to Section 39(2), the rights enshrined in the Bill of Rights of the Constitution ought to be prioritized in the development and promulgation of common and customary law (Republic of South Africa, 1996).

4.3.1.1. Non-derogable rights in South Africa

South Africa's Constitution protects the human rights to equality, dignity, life, and freedom and security of the person as stipulated by sections 9, 10, 11, and 12, respectively (Republic of South Africa, 1996). Furthermore, these rights are considered non-derogable rights, meaning that the rights are fundamental and cannot be suppressed or compromised (OHCHR, n.d.). The extent of the protections of these non-derogable rights has not been consistent. However, these inconsistencies can be justified. For example, the right to human dignity and the right to life, expressed in sections 10 and 11 are fully protected by the Constitution. Whereas the extent to which the right to Equality, expressed in Section 9 of the Constitution, is protected is only with regard to discrimination on the sole grounds of race, colour, ethnic or social, religion or language (Republic of South Africa, 1996).

Equality is a legal concept and a human rights principle that can be defined from both a descriptive and normative perspective as the state of being equal, particularly in status, rights, and opportunities (Capaldi, 2001). An equality approach that focuses solely on individual differences may be detrimental particularly for individuals who face intersectional discrimination, for example, black women and members of the lesbian, gay, bisexual, transgender, queer and intersex (LGBTQI) community (SAFMH, 2018). Despite the end of colonialism and the emergences of constitutional protection of human rights. discriminatory practices in mental health have become increasingly prevalent (Dhai, Gardner and Mahomed, 2021). This has been perpetuated by a lack of social and economic investment from government and decision-makers in health and legislative matters (Dhai, Gardner and Mahomed, 2021).

Therefore, a substantive equality approach is important because it expands the normative concept of equality through a transformative approach, namely, distributive justice which requires us to give special treatment to vulnerable individuals and promote social inclusion (Goldschmidt, 2017). However, in an inherently unequal world, hegemonic structures and systems favour patriarchal, racial, and other biased narratives. Furthermore, these hegemonies

challenge and, oftentimes, threaten seemingly neutral normative frameworks which, inadvertently, perpetuate privilege and deepen vulnerability (Goldschmidt, 2017).

As demonstrated by the historical development of psychiatric services in South Africa, the right to human dignity, life, equality, and freedom and security of a person cannot be separated from the right to health. Section 12 of the Constitution which guarantees the right to freedom and security of the person is non-derogable only with respects to subsections (1) (d) and (e), and subsection (2)(c) which includes the right:

> "(1)(d) not to be tortured in any way, and
>
> (e) not to be treated or punished in a cruel, inhuman or degrading way" (The Republic of South Africa, 1996).

Furthermore,

> "(2) Everyone has the right to bodily and psychological integrity which includes the right –
>
> …
>
> "(c) not to be subjected to medical or scientific experiments without their informed consent" (Republic of South Africa, 1996).

Lastly, Section 13 of the Constitution which prohibits slavery, servitude or forced labour is non-derogable with respect to slavery and servitude (The Republic of South Africa, 1996). These non-derogable rights stem from a complex and unjust history of human rights atrocities. Furthermore, these rights are paramount to the progressive realisation of rights particularly in the context of mental health. While negative Constitutional and Human Rights obligations (protections) are important, positive obligations (freedoms) in the form of reasonable socio-economic steps ought to be implemented to realise the right to equality (Section27, 2007), and hence the enjoyment of these rights by persons with mental health problems.

4.3.2. The role of International Law in South Africa

South African frameworks are heavily influenced by international human rights law and ethics. International, regional and national laws and legislations, more than above to govern and control the behaviour of individuals, additionally, ought to underscore the significance of

the protection and promotion of human rights. Human rights frameworks ultimately aim to set minimum standards for countries and their respective citizens through legally enforceable systems that hold countries and citizens accountable for human rights infringements. Ideally, international human rights frameworks ought to have an immediate effect in domestic contexts, giving individuals the liberty to seek remedies within their respective contexts. (Shyllon, 2009).

The international, regional, and national adoption of human rights frameworks in South Africa has been a major step in the right direction as it acknowledges the commitment towards social justice (Nathan, 2013). South Africa is one of the 51 founding members of the UN which now has 193 member states since its inception in 1945 (Republic of South Africa, 2006). In 2018, South Africa was invited to serve its third term on the United Nations Security Council (UNSC) at the 72nd Session of the United Nations General Assembly (UN General Assembly, 2018). Furthermore, South Africa has been an active participant in the UN's deliberative and subsidiary bodies, namely the General Assembly, the Economic and Social Council (ECOSOC), the UN Security Council, the Peace Building Commission (PBC), and the Human Rights Council (The Republic of South Africa, 2006).

International law has a dominant role in the promulgation and implementation of South African law, including mental health law. International normative frameworks, therefore, in the case of mental health, define the necessary conditions to address the ethical question of what ought to be done in order that the rights of MHCUs and patients in South Africa are respected.

4.3.2.1. Incorporation of International Hard law into South African domestic law

There are two types of systems used to incorporate law into domestic South African law, namely, monism and dualism. Monism, as a system, automatically enforces international law into domestic law upon ratification, just as domestic law is enforced through the court systems (Rosenthal and Sundram, 2004). Simply put, monism asserts that international and domestic law falls under one legal system. Whereas dualism requires domestic legislation to exist or be implemented prior to the enforcement of international law (Rosenthal and Sundram, 2004).

The Constitution of the Republic of South Africa Act 108 of 1996 (hereafter, the Constitution) is the supreme law of the country and it is the pinnacle for interpreting

international law in the domestic context (Section27, 2007). International law impacts South African health law and policymaking in both a direct and indirect way. Based on the general provisions in Chapter 14 of the Constitution, South Africa follows mainly a dualist system with elements of monism with regards to interpreting international law (Ferreira and Ferreira-Snyman, 2014). Regarding international agreements and sources of international hard law, South Africa mainly follows a dualist system. Provisions for international agreements are articulated in section 231 of the Constitution which states:

> "(2) An international agreement binds the Republic only after it has been approved by resolution in both the National Assembly and the National Council of Provinces…" (Republic of South Africa, 1996)

International treaty law in South Africa, therefore, requires incorporation into domestic legislation before it can be legally enforceable (Ferreira and Ferreira-Snyman, 2014). However, there is a monist element in the interpretation of some international agreements such as technical, administrative, and executive agreements. According to section 231(3) of the Constitution, these agreements do not require ratification nor accession and are binding to South Africa automatically without the approval from the National Assembly or the National Council of Provinces (Republic of South Africa, 1996).

In addition, subsection (4) of section 231 states that a self-executing provision of an agreement that has been approved by Parliament becomes law in the Republic unless it is in direct contravention of the Constitution or an Act of Parliament (Republic of South Africa, 1996). According to section 231(2) of the Constitution, through ratification, the provisions of international human rights frameworks are binding on the Republic of South Africa. Therefore, all international laws that confer protection in the context of mental health and that have been ratified by South Africa will be binding in the country as affirmed in the Constitution.

4.3.2.2. Incorporation of International Customary Law into South African domestic law

With regard to the interpretation of customary law, South Africa follows a monist approach. Evidence of this is found in section 232 of the Constitution which stipulates:

> "Customary international law is law in the Republic unless it is inconsistent with the Constitution or an Act of Parliament" (Republic of South Africa, 1996).

Section 233 of the Constitution further outlines the application of international law in South Africa stipulating that the courts ought to implement legislation that is consistent with international interpretations of that legislation.

Therefore, according to sections 232 and 233 of the Constitution, international customary law is directly enforceable before a South African court. Governments ratified to international human rights instruments are legally required to report back on the steps taken to implement adopted policies. However, very few governments have taken steps to ensure the fulfillment of these rights (WHO, 2005). Furthermore, the lack of accountability in both international and regional contexts with regards to implementation defeats the purpose of existing legal systems, further impeding the right to access mental health.

4.3.2.3. Sources of South African Law

South Africa has multiple sources and codes of law which can be found in various sources, namely, common law, customary law, case law legislation and traditional or indigenous law (The South African Government, n.d).

Case and Common Law

Case law refers to laws enforced by the courts which take into account previous court judgements. In addition to the Constitution and legislation, case law is often informed by common law (Legal Wise, 2020). Common law often applies to cases that are not governed by the Constitution or official legislation. South African common law comprises the 17th and 18th-century colonial Roman-Dutch law that was imposed onto the Cape upon its colonisation. Some common law crimes include rape, murder, and other society-related injustices (Legal Wise, 2020)

Legislation

Legislation refers to the laws enforced by the government or state of the country that is in authority. Legislation is powerful as it is often binding to the whole society and can be found in written documents referred to as statutes or acts. The South African Parliament is the highest authority that can pass and nationalise legislation. Similarly, provincial, and municipal authorities can pass provincial and local laws (The South African Government, n.d).

4.3.3. African Indigenous Law

In South Africa's modern socio-political context, common law is still binding on the nation despite its colonial transplantation into the South African social structure which almost displaced African indigenous law (The South African Government, n.d). Indigenous or African traditional law can be found in written and unwritten customary law and is applied through the regular courts.

Traditional customary law is the most indigenous law known to man which has been in existence long before the emergence of Roman and Dutch law in South Africa. Traditional customary law was not formally recorded as modern-day laws but was practiced by our ancestors and, for generations, has been binding on African communities (Mokotong, 2018). However, under colonialism, ATM and indigenous healing practices were not permitted as they were regarded as 'unscientific', 'uncivilised', 'backward', and 'superstitious' (Mothibe and Sibanda, 2019). These prohibitions were outlined in the Witchcraft Suppression Act of 1957 and the Witchcraft Suppression Act of 1970. Furthermore, the Medical Association of South Africa in 1953 interdicted the collaboration between western biomedicine and ATM. Similar to prejudiced notions predating the Era of Enlightenment about people with mental illnesses, ATM was not permitted because it was believed that illnesses in Africa were rooted in witchcraft (Mothibe and Sibanda, 2019).

Shortly after the WHO released the African Regional Strategy on Traditional Medicines, the Associated Health Professions Act No. 63 of 1982 was promulgated to try to regulate ATM in South Africa. The Associated Health Professions Act No. 63 of 1982, allowed for the registration and licensing of traditional health practitioners (THPs), namely herbalists, homeopaths, osteopaths, naturopaths and chiropractors. However, the Act denied THPs from providing healthcare under the title of "medical practitioner" (Mothibe and Sibanda, 2019).

The Allied Health Professions Act 63 of 1982, which established the Allied Health Professions Council of South Africa (AHPCSA), defines a medical practitioner as:

> "… a person registered as such under the Health Professions Act, 1974 (Act 56 of 1974)"

Furthermore:

> "a practitioner may-

(i) diagnose, and treat or prevent, physical and mental disease, illness or deficiencies in humans;
(ii) prescribe or dispense medicine; or
(iii) provide or prescribe treatment for such disease, illness or deficiencies in humans;" (Allied Health Professions Council of South Africa, 1982).

Legislation regulating ATM and healing practices predating 1994 reflected the colonial context at the time. Indigenous African communities were oppressed for generations across most, if not all, social structures. The legislative limitations by the two abovementioned acts imposed further limitations on the right to access health care among black and other African communities.

These laws applied to all South African provinces with the exception of KwaZulu-Natal, which was governed by the KwaZulu-Natal Act on the Code of Zulu Law (CZL) which was promulgated in 1981. THPs registered under the CZL were allowed to claim fees for the provision of healthcare (Mothibe and Sibanda, 2019). Furthermore, according to the Evidence Amendment Act (No. 45 of 1988), Indigenous law holds authority on the condition that it does not contravene the principles of public policy or natural justice. Moreover, the Black Administration Act of 1927 allows for partial codification of indigenous principles as demonstrated by the CZL (The South African Government, n.d).

Although there has been a gradual process in institutional research and collaboration, there is an increasing need for more robust guidance and implementation of ATM or traditional healing at primary health care (Mothibe and Sibanda, 2019). Notwithstanding the challenges delaying the enactment of the Traditional Health Practitioners Act, the registration, training, and acceptance of THPs ought to be prioritized to increase safe, adequate, and decolonised access to health, particularly amongst black South Africans within the mental health care context.

4.3.4. Present-day Mental Health Protections in South Africa

It has almost been 370 years since the colonisation of the Cape which has resulted in a deeply racial and socio-economically skewed South African legal system. The formation of the South African Union in 1910, ironically, did not represent the interests of the overall South African population. Instead, this Union served as a reflection of the English and Afrikaans alliance (The South African Government, n.d). South Africa's legal system ought to be scrutinized to

reflect the post-colonial, or democratic values, namely equality, dignity, and freedom. Mental health legislation is a positive step in the promotion of mental health and represents the progressive realisation of the Constitution's promise in section 27. In South Africa, mental health laws have been adopted and amended over time to keep up with international and national socio-economic and socio-political developments (Gillis, 2012).

The National Department of Health (NDoH) committed to the Mental Health Policy Framework and Strategic Plan (MHPF) 2013–2020 was promulgated in 2013 to integrate mental health into community and PHC services (Docrat, Lund and Chisholm, 2019). As 2022 approaches, the goals and objectives of the MPHF are yet to be implemented after meeting several critical challenges. The main challenges associated with implementing the MPHF are mainly the lack of dedicated budget for mental health services and inadequate articulation of mental health priorities in related policies and programmes (Docrat, Lund and Chisholm, 2019).

4.3.4.1. The Mental Health Care Act No. 17 of 2002 and the Mental Health Care Amendment Act No. 12 of 2014

The promulgation of the Mental Health Care Act of 2002 ("MHCA") came eight years after the end of apartheid. Formerly known as the Mental Disorder and Defective Persons Act of 1916, the Mental Health Care Act of 2002 has been amended over time to adapt to the ever-changing context of mental health (Gillis, 2012). The MHCA was signed in 2002 but only came into force in 2004, the same year as the enforcement of the National Health Act 63 of 2003. Currently, South Africa is under the administration of the Mental Health Care Amendment Act No. 12 of 2014 which came into force on the 30th of July 2016 (Szabo and Kaliski, 2017). The amendment was aimed at providing delegation of powers by the head of national department and to annul the Mental Health Act 18 of 1973 (Republic of South Africa, 2020).

In accordance with the Constitution, South Africa's modern mental health care acts have been premised on human rights principles and embody the WHO's Ten Basic Principles guiding mental health care which provides guidance on the treatment and care of persons with mental health conditions (South African Lancet National Commission, 2019). Moreover, the MHCA

Act No. 17 of 2002 was a major attempt to mitigate negative reactions against South Africa's inhumane mental health context and to address the legacy of human rights abuses in psychiatry (Ure, 2009).

Changes from the Mental Health Act of 1973 to the 2002 MHCA were mainly semantic and for public relations. While the Mental Health Act was concerned with the "reception, detention and treatment" of 'psychiatric patients', the MHCA on the other hand is concerned with the "care, treatment and rehabilitation" of 'mental health care users' (Ure, 2009). The Mental Health Care Act 17 of 2002 defines an individuals' mental health status as the level of mental well-being influenced by social, physical, and psychological factors which could result in a psychiatric diagnosis (Republic of South Africa, 2004). The shift from a strictly biomedical model of health to a biopsychosocial model is observed under the MHCA that acknowledges the influence of multidisciplinary factors in psychiatric diagnosis and mental health care provision.

Although deemed as one of the most progressive legislations in the world, the implementation of the MHCA No. 17 of 2002 was faced by several challenges, namely inequity in resource distribution, implementation challenges, shortage of psychiatrists, and inadequate community psychiatric services (Sukeri, Betancourt and Emsley, 2014). In 2006/7, the National Department of Health (NDoH) set up three task teams to monitor the implementation of the MHCA No. 17 of 2002 with the objectives of identifying 28 designated facilities for community services and increase the number of beds by 150. In 2014, little progress had been made with only 8 facilities identified and no increase in the number of beds (Sukeri, Betancourt and Emsley, 2014).

Mental health legislation, namely the Mental Health Care Act No. 17 of 2002 and the Mental Health Care Amendment Act 12 of 2014 provide for the right to access mental health in South Africa (Republic of South Africa, 2020). However, in terms of the progressive realisation of this human right has been met by severe and detrimental challenges. In today's context, the NHI policy unequivocally is the most relevant framework in achieving universal health coverage in mental health care. The NHI is necessary as it is expected to bridge the gap between policy and implementation, particularly in South Africa's deeply fragmented mental health context (South African Lancet National Commission, 2019).

4.3.4.2. The National Health Insurance Policy and Bill and their role in Mental Health

The NHI Bill was released on the 15th of August 2019 with the aim of creating universally accessible and sustainable health care for all through a single government-controlled fund funded through mandatory prepayments from taxpayers in South Africa (South African Government, 2019). The NHI's objectives strongly embody human rights and bioethical principles which are essential for addressing the right to access to fair and equitable healthcare (Department of Health, 2017). With regard to mental health care, the NHI Policy (White Paper) gives more consideration to the interventions involved, whereas the NHI Bill merely underscores the rights enshrined in mental health and the possibility of amending the legal frameworks enshrining these rights (Department of Health, 2017; Republic of South Africa, 2019).

While the NDoH is responsible for the promulgation of mental health policy and laws, the delivery of social services such as health care is the responsibility of provincial health departments and local authorities (WHO, 2008). As such, the NHI proposes an administrative shift in who controls health budgets, moving from the fragmentation of resources, referred to as 'provincial equitable share allocation', between national and provincial to a single, state-controlled medical fund (Dhai, Gardner and Mahomed, 2021). The separation of the financing and distribution of healthcare services provides the government the opportunity to cater to vulnerable and underserviced populations through contracting private service providers to fill the gaps (Dhai, Gardner and Mahomed, 2021).

The implementation of the NHI began in 2012 to be continued over a 14-year period in three phases. The administrative shift is premised on the notion that health is a social solidarity issue (South African Government, 2019). Phase 1 already took place between 2012 and 2017 and was focused on health system strengthening activities funded by the NHI Conditional Grants and Health Infrastructure Grants (South African Government, 2019). These activities were tested in 11 districts and included integration of school-health programmes, incorporation of district clinical specialists, the establishment of the Office of Health Standards, and contracting healthcare service providers and health establishments (South African Government, 2019). In accordance with Section 5 of the NHI Bill, PHC and hospital

levels will be entered into based on the health needs of the health care user through the relevant referral pathways (Dhai, Gardner and Mahomed, 2021).

Phase 2, which started in 2017 and is to end in the year 2021, has been centred around advancing legislation and relevant amendments (South African Government, 2019). Furthermore, funds from the Compensation Fund and the Road Accident Fund have been redirected to the NHI fund. Subsidies to medical aid schemes are undergoing a similar process. Activities during this phase include procurement of personal healthcare services from Emergency Medical Services (EMS) and National Health Laboratory Services (NHLS) targeted for vulnerable groups (South African Government, 2019).

Lastly, phase 3 is set to also begin in 2021 and conclude in 2026. In accordance with section 2 of the NHI Policy, the NHI will be financed through funds pooled from personal income tax in the form of mandatory prepayments to ensure quality and affordable healthcare for all South Africans, regardless of their socio-economic status (South African Government, 2019). Furthermore, comprehensive health care services that will be offered under this policy will be achieved by using an NHI card from the nearest facility to the individual's home or work (South African Government, 2019). Under the NHI, medical aids can only offer complementary services or as a top-up service not covered by the fund (Department of Health, 2017).

Chapter 3.2 section 48 of the NHI White Paper policy identifies the influence of SDH on the high disease burden of non-communicable diseases (NCDs) such as mental health, in South Africa's society (Department of Health, 2017). Furthermore, the NHI Bill recognises the need to address historical socio-economic imbalances in order to provide mental health care services in line with the standards set in Article 12 of the ICESCR and Article 16 of the Banjul Charter which ascertain the right to the highest possible standard of quality mental health care for all (Republic of South Africa, 2019).

Section 48 of the NHI white paper policy further stipulates that:

> "The lack of focused health promotion and prevention programmes and interventions, poor health seeking behaviour and the late detection of diseases are some of the major factors contributing to the high burden of NCDs. Low levels of physical activity affect

45.2% of women and 29.9% of males aggravating the prevalence of NCD's." (Department of Health, 2017).

As a result, the NHI Policy proposed the Integrated School Health Programme (ISHP) where promotive, preventative and curative services ought to be prioritised across various health services including mental health (Department of Health, 2017). Furthermore, the Policy promised that mental health screening would be prioritised in the phased implementation of purchasing NHI service benefits (Department of Health, 2017). Despite these promises, mental health care has been sidelined as the ISHP failed to identify learners with mental health or substance use conditions (Docrat, Lund and Chisholm, 2019).

The South African Department of Health (DoH) is working with the Council for Medical Schemes (CMS) to ensure all medical aids pay for the same package of PHC services received by and provided for the public. This is supported by and enshrined within the NHI in Section 3.3.5 as part of the Prescribed Minimum Benefits (PMBs) revision (Department of Health, 2017). Sections 35 and 41 of the NHI stipulate that healthcare facilities ought to be paid directly for their services, therefore, empowering healthcare facilities with more control over health budgets (Department of Health, 2017). This differs from the previous administrative system of a sole health care provider and purchaser.

The NHI is an important step towards prioritising mental health care services in PHC. However, both the white paper and policy do not provide an adequate plan nor the details of the primary health care approaches specific to mental health to be implemented. Furthermore, the NHI will only take full effect in a few years' time, however the mental health crisis in South Africa is ongoing and has been exacerbated by the current COVID-19 pandemic.

4.4. Conclusion

Human rights frameworks are intended to protect the human rights of everyone in society, including people with mental health conditions Throughout history, the South African mental health context has been subjected to extreme resource constraints and limitations. Allocation and distribution of healthcare resources can be highly problematic and detrimental for health care recipients and users in South Africa. National legislation ought to promote equal access to state services and resources; be free from prejudice and prevent unnecessary provincial action. Implementation of constitutional measures to achieve the progressive realisation to fundamental human rights, particularly the right to access mental health, has often been

stunted by alleged resource limitations. The most recent amendment of South Africa's Mental Health Care Act presents a fundamental shift from previous mental health policies and the implementation of the NHI aims to mitigate these tensions and disparities in mental healthcare provision.

Chapter 5: Mental health vulnerability in the African Context

Despite the many international and regional human rights protections, the right to access dignified and equitable mental healthcare in South Africa is yet to be realised in its entirety. This is due to limitations imposed by a plethora of social and economic challenges, which further perpetuate vulnerability in mental health. (Ure, 2009; van Rensburg and Fourie, 2016). In response to Objective 3, this chapter critically analyses the intergenerational vulnerability in mental health, with an emphasis on the African context.

5.1. Vulnerability in the context of Mental Health

Mental health vulnerability in the African context is mainly attributable to colonialism, poverty, racial and socio-economic inequality, exposure to unhealthy environments, premature mortality, stigma and discrimination, social exclusion, inadequate implementation of policies and laws, unethical execution of responsibilities of health care professionals, resource mismanagement, lack of accountability, and unfair distribution of resources resulting in limited access to health and other social services (Dhai, 2020; Spamers, 2016). Additionally, vulnerability to mental illness is heavily influenced by various factors including genetics, geography, social dynamics, and the historical underpinnings of a country.

Poor mental health conditions and mental illnesses can affect anyone; however, some people have underlying determinants that can make them more susceptible and vulnerable to the onset and manifestation of mental illnesses (Matlala et al., 2018). Vulnerable groups have been identified in the NHI as women, children, older persons, and people with disabilities under Chapter 1, Section 4(2)(d) of the NHA (Department of Health, 2017).

In the context of South Africa's gender-based violence, women face an increased risk of developing severe mental illnesses such as depression. People living with HIV (PLHIV) also face an increased risk of mental illness which can have detrimental consequences on their adherence to antiretroviral (ARV) medication (SADAG, 2020). Additionally, homeless people; unemployed people; individuals with low or no levels of education; indigenous populations; the youth, the elderly; neglected populations, and survivors of abuse, assault,

rape, and Gender-based Violence (GBV) have all been identified as vulnerable groups (Dhai, Gardner and Mahomed, 2021; SAFMH, 2018) with potential for mental health problems.

As mentioned in Chapter 1 section 1.10, the NHI aims to achieve sustainable universal access to quality health care. Although the NHI claims to provide universal health coverage, this is strictly limited to South African citizens, thus excluding neglected populations, namely, asylum seekers and undocumented migrants. However, asylum seekers and undocumented migrants have been identified as a vulnerable group in Article 4 of the Vienna Declaration (World Conference on Human Rights, 1993).

Furthermore, members of the LGBTQI community have also been identified as a vulnerable group who have been neglected and marginalised, particularly in the context of HIV and mental health (United Nations Development Programme (UNDP), 2021). Prior to the 1970s, homosexuality was classified as a mental disorder until the APA's Committee on Nomenclature, headed by Robert Spitz at the time, was pressured to remove it from the DSM-III. This occurred after critical reviews of the previous editions of DSM and reflection of the growing stigma in mental health research as a result of discriminatory classifications used in that period (Telles-Correia, Saraiva and Gonçalves, 2018).

The Constitutional right to access healthcare in South Africa provides for all residents within South Africa (The Republic of South Africa, 1996; The Republic of South Africa, 2019). This protection ought to extend to all members of society, including socially marginalized groups. According to the NHI, asylum seekers and undocumented migrants are only eligible to receive healthcare under the NHI policy if it is either an emergency situation or if they have conditions of public health concern. This is in line with Section 27 of the Constitution and seems justified when factoring in South Africa's resource constraints. However, one cannot help but note the contradictory aspect of the NHI Bill that aims at providing universal health care access and addressing the social determinants of health but excludes certain groups within South Africa's society. Irrespective of their legal citizenship status, asylum seekers and undocumented migrants in South Africa still form part of our society and contribute to the economy of the country albeit informal.

Neglected and vulnerable populations may have access to health coverage with regard to the COVID-19 pandemic and other issues of public health concern, however, with regard to their mental health "pandemic" they face exclusion based on their social and civic status. Because

of the exacerbation of mental ill health during the infectious disease outbreak, mental illness is now being referred to as a "Parallel Pandemic" by the United Nations and some experts (United Nations, 2021). The COVID-19 pandemic has reinforced that the exclusion of any group from accessing mental healthcare creates a potential risk for complex public health outcomes as well as low socio-economic development, thereby making the vulnerable even more vulnerable.

5.2. Mental Health Vulnerability in Africa: A Pertinent Case in Common Law

The link between mental health, human rights, and socio-economic development is underscored in the case of *Purohit & Moore v The Gambia* 2001 (1) AfCHPR [241] where mental health advocates representing detained patients at Campama, the Psychiatric Unit of the Royal Victoria Hospital, complained about the outdated Mental Health Acts of the Republic of the Gambia. The Lunatics Detention Act (LDA) served as the primary framework governing mental health. However, LDA does not adequately define who a lunatic is and fails to provide measures to safeguard patient's diagnosis, certification. and detention. Similar to South Africa's mental health context, overcrowding in the psychiatric units is prevalent among the institutions in the Gambia. Overcrowding in mental health institutions poses multiple threats to the provision of treatment from both a bioethical and legal standpoint. In the case of *Purohit & Moore v The Gambia* (2001) AfCHPR [241], the moral obligation to obtain informed consent was violated and the patients no longer received continued care. The complainants emphasized the lack of remedial pathways for violations committed under the LDA to the African Commission.

Furthermore, the complainants alleged that there were violations of the Banjul Charter, specifically, Articles 2, 3, 5 7(1)(a), 13(1), 16, and 18(4) [refer to Table 2 in chapter 4 section 2 for full description of human rights protections in Africa]. The African Commission examined the complaints and requested additional information in terms of Article 56 of the Banjul Charter which was later forwarded to the Respondent State. Article 56 of the Banjul Charter assesses the permissibility of communication brought forward by African states.

Furthermore, Article 56(5) of the Banjul Charter stipulates:

> "Communications … received by the African Commission shall be considered if they: (5) are sent after exhausting local remedies if any unless it is obvious that this procedure is unduly prolonged" (Organization of the African Union, 1986).

In essence, complaints brought forth to the African Commission ought to be done only after exhausting local legal remedies. In this case, the Complainants were unable to exhaust these channels as the local laws of The Gambia, specifically mental health laws do not provide pathways for legal dispute. In particular, the complainants argued that the LDA does not outline appeal procedure for wrongful detention, diagnosis, or treatment of patients with mental illnesses, Moreover, the LDA does not permit patients to legally challenge the separation of their medical certificates which provide the basis for their detention (*Purohit & Moore v The Gambia* (2001) AfCHPR [241]).

In response, the Respondent State affirmed that diagnosed 'lunatics' were informed of their right to request assessment reviews and alluded to the fact that the Gambia had further legal provisions that protected vulnerable groups. In the Gambia, Common law is recognized under national law in accordance with Section 7(d) of the Constitution of The Gambia. The Respondent State also alluded to the fact that the Complainant could bring forward action of tort against the alleged wrongful detention under the common law of the country. The Respondent State added that patients detained at Campama Psychiatric Unit, under the LDA, could further challenge this decision in the country's Constitutional Court in accordance with the Gambian Constitution (*Purohit & Moore v The Gambia* (2001) AfCHPR [241]).

The Complainant's key concern was the lack of review processes against voluntary and involuntary detention of mental health patients thus if an error had been made in diagnosis, no remedy could be taken. This has been particularly problematic within the Gambia because mental health patients are sometimes examined by general practitioners as opposed to qualified psychiatrists. The African Commission, therefore, ought to identify possible domestic remedies for the Complainant as the Respondent State indirectly admitted to the legislative loopholes within the LDA, revealing plans for future amendments of the Act (*Purohit & Moore v The Gambia* (2001) AfCHPR [241])

Although the Respondent State alluded to the Constitutional legal remedies available to patients and the Complainants, the state also acknowledged the existing legal limitations faced by vulnerable groups that often struggle to access legal procedures within the Gambia.

Instead, legal assistance is readily available for persons charged with capital offenses according to the Poor Persons Defence (Capital Charge) Act. 35.

The African Commission concluded that general provisions in the Gambian law permit wealthier populations that can afford private counsel to seek legal remedies and procedures. Therefore, the domestic legal remedies within the Gambia are not absent per se but are extremely inaccessible for populations with lower socio-economic development (*Purohit & Moore v The Gambia* 2001(1) AfCHPR [241]). This case is just one example one of the vulnerabilities associated with accessing social justice in the context of mental health in the African region.

5.3. Smith-Mitchell Transfers

The Smith-Mitchell Organisation was a private organization that provided custodial care. In 1962, the apartheid Department of Health (DoH) provided the Smith-Mitchell Organisation with a contract to house and treat certified patients under the Mental Health Act of 1973 (Ure, 2009). In 1974, the apartheid government authorised the Smith-Mitchell Group to relieve the DoH of the overflowing chronic mental health patients. This deinstitutionalisation attempt was in accordance with sections 8 and 16 of the Mental Health Act of 1973 (Ure, 2009).

The Smith-Mitchell Organisation was a leading institution licensed to detain predominantly black people with alleged mental illnesses. This was done, allegedly, to reduce overcrowding of state institutions. Overcrowding remains a prominent feature in South African public institutions, with discrimination being at the forefront of challenges faced in both the historical and current mental health context (Gillis, 2012).

The morality of the Smith-Mitchell private institutions was called into question by the President of the South African National Council for Mental Health who referred to these institutions as “human warehouses” (Ure, 2009). Some civil society members opposed this move, but the SASOP and the American Psychiatric Association (APA) reassured both government and society that the facilities were well-equipped to provide appropriate mental health care (Gillis, 2012). Concerns grew among health care practitioners with multiple public statements from the MASA and the SASOP executive committees speaking out against unethical practices disguised as psychiatry. The statements made by HCPs underscored how

psychiatric diagnoses and treatment ought to be free from discrimination and unethical socio-political interference (Ure, 2009).

Even though the APA had initially approved the segregationist transfers to the private facilities, they later found evidence of discriminatory care based on socio-cultural and socio-political conflicts in the mental health context (Ure, 2009; AAAS, 2005). Furthermore, hospital confidentiality policies prohibited families from contacting hospitals to enquire about their admitted family members (Ure, 2009). The Smith-Mitchell Organisation profited immensely from this contractual arrangement (Ure, 2009). Moreover, the private custodial facility was maintained through the peonage and unpaid labour of the black mental health care patients saving the organisation even more money (Ure, 2009). As a result, the patients at the Smith-Mitchell facilities were exploited to cut governmental costs and used as a means to an end (Ure, 2009).

After 1994, the Smith-Mitchell custodial care institutions had a total of 15 000 patients who were removed from their families and communities over 47 years ago. Moreover, these patients were institutionalised without any psychiatric diagnoses (Ure, 2009). The abolition of apartheid was the first step towards eradicating health problems faced by the black community (AAAS. 2005). While that has been done on paper, inequality and inequitable access to social services, specifically mental health care, continues in the current context of South Africa.

5.4. The Life Esidimeni Tragedy

40 years after the Smith-Mitchell tragic transfers, history repeated itself with the Gauteng Mental Health Marathon Project (GMHMP), also known as the Life Esidimeni (LE) Tragedy. It is important to note that the Smith-Mitchell Organisation and the Life Healthcare Group fall under the same group (Ure, 2009). Moreover, Life Esidimeni is a private company and subsidiary of the Life Healthcare Group that provides highly specialized medium-to-long-stay mental hospital care (Dhai, Gardner and Mahomed, 2021).

During the period between March 2015 and June 2016, the Gauteng Department of Health (GDoH) authorized the criminal and unethical transfer of 1442 patients diagnosed with severe mental illnesses or severe intellectual disabilities from the Life Esidimeni facilities, into the ‘care’ of, mainly unlicensed NGOs (Dhai, Gardner and Mahomed, 2021). Several complex ethical, human rights and legal issues have emanated from the LE transfers that severely

affected patients and families. Furthermore, the GDoH rejected the proposal from Life Esidimeni to purchase their facilities and, instead, sent patients to ill-equipped and unlicensed NGO facilities (Report of Proceedings of Life Esidimeni Arbitration at Emoyeni Conference Center, 2017).

The GDoH argued that their decision-making was in accordance with deinstitutionalisation and the Mental Health Care Act (MHCA) No. 17 of 2002 which supports mental health care through community integration (Republic of South Africa, 2004). However, the main reason for the LE transfers was to cut costs and for government to save money. This specific move for deinstitutionalisation or community integration was opposed by some patients' family members as they feared that the NGOs would, firstly be inaccessible to the families, and, secondly, that the NGOs would provide low-quality care (Dhai, Gardner and Mahomed, 2021). In some instances, family members were not even contacted nor alerted about the transfers. As proof of this opposition, the South African courts were approached and consulted on two occasions in a plea to prevent the LE transfers from occurring. In both instances, judges ruled in favour of the GDoH on the condition that the contracted facilities, i.e., 27 NGOs and 2 specialised psychiatric hospitals, maintain the standard of care provided by Life Esidimeni (Section27, 2018; Dhai, Gardner and Mahomed, 2018).

In September 2016, the former Member of the Executive Council (MEC) for health, Qedani Mahlangu, announced in the provincial legislature that 36 patients had died during the LE transfers, causing widespread public outcry. In turn, the Ministry of Health (MoH) requested that the Office of the Health Ombud (OHO) investigate the circumstances surrounding the deaths (Section27, 2018). By August 2017, it was found that 131 patients had died as a result of this move. The LE transfers occurred over 23 months between October 2015 and August 2017 and have been divided into three periods. During the first 6 months of the transfer, 92 mental health patients had died and 119 by the end of the first year. The age-adjusted death rate was 63/1000 for the patients involved in the transfers. Robertson and Makgoba (2018) indicated that the standardized mortality ratio was quite high with predicators attributable to increasing age and the transfer destination. It was found that higher survival rates were observed amongst the patients transferred to specialized hospitals (Dhai, Gardner and Mahomed, 2021).

By the end of June 2016, all patients were either discharged or transferred to alternative care from Life Esidimeni. Initially, transfers occurred in small groups of approximately 10 – 20

patients. Then towards the last two months of the transfer, there was a disproportionate increase with 1 000 patients being transferred during this time. On some occasions, some patients were transferred up to three times before their final destination. For some patients, the destination was not reached as they died during the transfer process (Dhai, Gardner and Mahomed, 2021).

The patients that survived this tragedy were subjected to numerous injustices. Some patients were transported in open trucks during the winter with some mechanically strained in order to prevent them from falling out of the vehicle. When they arrived at the NGOs, patients were lined up, similarly to an auction, where the staff randomly selected patients that they wanted to keep. To add to the issues, due to delays in payments from the GDoH, patients starved as they were not provided with food and, in some cases, they were deprived of water (Dhai, Gardner and Mahomed, 2021).

5.4.1. The violation and derogation of Fundamental Human Rights during the Life Esidimeni tragedy

The Arbitration proceedings for the LE Tragedy were presided over by Justice Dikgang Moseneke, who was given the responsibility of determining the nature and extent of equitable redress within the rights of affected parties, namely patients and their families (Dhai, Gardner and Mahomed, 2021). The retired Deputy Chief Justice described the LE tragedy as follows:

> "This is a harrowing account of the death, torture and disappearance of utterly vulnerable mental health care users in the care of an admittedly delinquent provincial government. It is also a story of the searing and public anguish of the families of the affected mental health care users and of the collective shock and pain of the many other caring people in our land and elsewhere in the world." (Moseneke, 2018; para 1; Section27, 2018)

While the GDoH, MEC for health, and other involved perpetrators were found to be in contravention of several constitutional damages, the perpetrators were not held criminally accountable for the criminal actions that led to the deaths and tragedies of the mental health care patients discharged from Life Esidimeni (Dhai, Gardner and Mahomed, 2021).

The main issue with the GMHMP was the blatant violation of fundamental human rights, namely the right to life, the right to access healthcare, and the right to dignity amongst others

(Dhai, Gardner and Mahomed, 2021). Based on the lack of agency in decision-making processes, the patients with severe mental illnesses have what is known as diminished autonomy and, as such, are particularly vulnerable to external or controlling influences (Dhai, 2019). The strong paternalism demonstrated by GDoH, and the dual loyalty of the HCPs and contracted stakeholders involved in the LE tragedy vehemently disrespected and violated the patients' non-derogable rights to dignity, life, and equality.

According to the WHO definition of health, the PHAC definition of mental health, and the many human rights instruments protecting mental health, the right to access healthcare is closely related to the right to dignity (WHO, 2018; PHAC, 2006). Dignified healthcare ought to be provided without the distinctions of,

> "race, religion, political belief, economic or social condition*"* (WHO, 1946).

The irrationality of decision-making in the LE tragedy resulted in morbidity and mortality. The right to life is intricately linked to the right to access healthcare and both were infringed. (Dhai, Gardner and Mahomed, 2021).

5.4.1.1. International and Regional Violations by the Gauteng Department of Health

The right to health entails freedoms, such as the right to control one's health and body and the protection from interference such as torture, non-consensual treatment, and experimentation (Republic of South Africa, 1996). The ICESCR is viewed as the central international human rights instrument for protecting the right to health and recognizes the inherent dignity in all human beings (Ferlito and Dhai, 2017; United Nations, 1976). Article 12 of the ICESCR underscores the right to enjoy the highest attainable standard of physical and mental health.

The African Charter on Human and People's Rights (Banjul Charter) officially established African people's right to health (Dhai, Gardner and Mahomed, 2021). Article 16 of the Banjul Charter, i.e., the right to the best attainable physical and mental health is an immediate right as the regional instrument makes no mention of "progressive realisation". In the LE Tragedy, NGOs and individuals had limited access to this fundamental human right, among many other socio-economic and socio-political rights enshrined within the Banjul Charter.

In total disregard of their public service oath and in contravention of the core values of healthcare practice, the members of the GDoH agreed to and signed off on decisions that were detrimental and that led to the LE tragedy. The UDHR emphasizes that for the right to health, adequate, which translates to *dignified*, standards of living are required (UN, 1948).

The right to dignity is enshrined and protected by multiple international, regional, and national legal and ethical instruments, (see Tables 1 and 2 in chapter 4), namely:

- Articles 1 and 22 of the Universal Declaration of Human Rights (UN, 1948)
- Articles 1 and 3 of the Convention on the Rights of Persons with Disabilities (UN, 2008)
- Principle 3 of the United Declaration on Rights of Disabled Persons (UN, 1975)
- Principle 10 of the Declaration of Lisbon on the Rights of the Patient (World Medical Association, 1981)
- Article 5 of the Banjul Charter (African Charter on Human and People's Rights, 1986)
- Article 22 of the Protocol on Health (SADC, 1999).

The GDoH commissioned these acts under the auspices of the law which is in direct contravention of Article 27 of the Vienna Declaration (Dhai, Gardner and Mahomed, 2021; United Nations, 1969). While some inconsistencies in the protection of non-derogable rights may be defensible, the actions that led to and occurred during the LE transfers resulted in excessive, yet avoidable morbidity and mortality and were simply unjustifiable (Dhai, Gardner and Mahomed, 2021).

5.4.1.2. National derogation of the rights of the mental health care users involved in the Life Esidimeni tragedy

South Africa's comprehensive Constitution comprises both freedoms and entitlements including the right to access health which is articulated in section 27 of the Constitution. However, Section 27(2), in conjunction with the Limitation of Rights clause in section 36 of the Constitution, has often been used as a scapegoat for grave human rights injustices and for government to evade accountability with regard to the allocation and distribution of state and public resources.

Table 3 in the following subsection, provides a summary of the derogation of the rights of the mental health care patients affected by the Life Esidimeni tragedy. As mentioned in chapter 4

section 4.3.1.1, non-derogable rights outlined in South Africa's Constitution include the right to human dignity, the right to life and the right to equality with respect to unfair discrimination (Act No. 108 of 1996).

Table 3: The Derogation of Non-derogable rights by the GDoH in the Life Esidimeni tragedy under South African laws and protections

Legal / Ethical Instrument	**The Right to Human Dignity**	**The right to life**	**The right to equality (with respect to unfair discrimination)**
The Constitution of the Republic of South Africa (Act No. 108 of 1996) *Hard law*	Section 10 "Everyone has the inherent dignity and the right to have their dignity respected and protected"	Section 11 "Everyone has the right to life"	Section 9 (3) "The state may not unfairly discriminate directly or indirectly against anyone on grounds, … disability…"
***The National Health (Act No. 63 of 2003)** *Hard law*	Not Applicable.	Preamble: "The need to improve the quality of life of all citizens…"	Not Applicable.
The Mental Health Care (Act No. 17 of 2002) **The Mental Health Care Amendment (Act No. 12 of 2014)**	Chapter 3 (8) Respect, human dignity and privacy Respect for dignity and privacy of every MHCU. "Improve the mental capacity of the user to develop to full potential and to facilitate his or her	Not Applicable.	Not Applicable.

Hard law	integration into community life proportionate to his or her mental health status"		
The Patient Rights Charter (HPCSA: Booklet 3) *Ethical guidance*	"Participation in decision-making. Access to healthcare; Choice of health services; … Confidentiality and privacy; Informed consent…"	"...a healthy and safe environment that will ensure physical and mental health or well-being, including adequate water supply, sanitation and waste disposal…"	Not Applicable.
Batho Pele (1997) *Ethical guidance for HCPs*	Code of Conduct "Treat all customers with equal dignity;" (pg. 89)	'Involve customers and staff: ...." On how to enhance/improve life (pg. 169)	"… a safe and civilised society in which all have equal opportunity for social and economic development" (pg. 28)

*The NHA is inherently flawed as it fails to protect the dignity of patients and health care users in South Africa. Accessing adequate health care is intricately linked and indispensable to the right to dignity. The realization of this right is however, not protected by this legislative framework. Instead, the NHA stipulates in Chapter 2 section 19 that the health care user ought to treat HCPs with respect and dignity (Republic of South Africa, 2004). The NHA only highlights the protections of HCP, making no mention of non-derogable protections of health care users and patients (Republic of South Africa, 2004). This lack of statutory protections for patients could further increase their susceptibility to vulnerability inherent in their encounters in the healthcare context.

Despite the tragic deaths, among other criminal infringements that occurred during the LE's illegal and unethical transfers, the National Prosecuting Authority (NPA) denied criminal

prosecution of the involved perpetrators (Dhai, 2020a). The GMHMP was tragic for South Africa because the state, which ought to be the custodians of justice, failed to uphold its Constitutional promise to the vulnerable mental health patients from Life Esidimeni and their families (Dhai, Gardner and Mahomed, 2021).

5.4.2. Dysfunctional department of health in South Africa

Despite their moral obligation and the presence of numerous legal and professional instruments, custodians within the GDoH, who took an oath to always act in the best interest of the patient and in a manner that does not harm or put at risk the human rights of individuals in society, exposed the dysfunctional state of South Africa's health department. The necessary factors for a country's health system have been stipulated by the CESCR and include access, acceptability, availability, and quality (OHCHR, 2000; Dhai, Gardner and Mahomed, 2021).

Availability is required to address underlying social determinants of health such as safe drinking water, adequate sanitation facilities, and trained medical personnel (Dhai, 2020b). During the LE tragedy, there was a lack of sufficient drinking water, resulting in severe dehydration among the patients. There was a lack of sanitation facilities and essential medicines, in contravention of Principle 9 and 10, respectively, of the MI Principles (Dhai, Gardner and Mahomed, 2021; United Nations, 1990). Furthermore, the NGO staff contracted to care for the patients were not trained medical personnel.

Accessibility refers to universal access to health care facilities, resources and services without discrimination (Dhai, Gardner and Mahomed, 2021). Non-discrimination is essential to achieve the highest attainable standard of health and for a functioning health system. Stigmatizing and discriminatory attitudes were blatant in the LE tragedy, directly violating Section 9 of the Constitution and Article 25 of the CRPD (Dhai, Gardner and Mahomed, 2021).

Acceptability refers to healthcare facilities and services that respect health law and ethics to improve the health outcomes of patients within a community (OHCHR, 2000). In the case of the LE tragedy, no health outcomes were improved; instead, patients suffered unnecessary morbidity and mortality.

Quality refers to health facilities, resources, and services that are both culturally acceptable and medically appropriate as supported by Article 25 of the CRPD and section 66(b) of the

MHCA Act No. 17 of 2002 (OHCHR, 2000; Dhai, Gardner and Mahomed, 2021). A health facility has been defined as a pace designed specifically to provide healthcare treatment on both an inpatient and outpatient basis (Dhai, Gardner and Mahomed, 2021). In addition to the CRPD and MHCA, the GDoH was in direct contravention of core bioethical principles as well as Section 24 of the Constitution which stipulates everyone right to an environment that does that harm one's health or well-being (Dhai, Gardner and Mahomed, 2021; Republic of South Africa, 1996).

Instead, patients involved in the GMHMP were removed from functioning health facilities and taken to the NGO properties that lacked the capacity, skills, and competence to care for the mental health patients (Dhai, 2020b; Dhai, Gardner and Mahomed, 2021). The maltreatment of MHCUs and mental health patients demonstrated by South Africa's custodians of health, both colonial and post-democratic, was a grave injustice in direct contravention of bioethics and human rights. Specifically, deontological ethics under which Kant formulated three categorical moral imperatives. One of which stipulating that an individual ought to:

> "Act in a manner so as to treat humanity, whether in your own person or that of any other person, never solely as a means but always also as an end" (Dhai, McQuiod-Mason and Knapp van Bogaert, 2011, pg. 9).

Based on the deficiencies exposed by the LE tragedy, patients involved in the GMHMP did not have access to a functional health system as they were treated solely as a means to an end, resulting in unfortunate morbidity and mortality, amongst other human rights violations.

5.4.2.1. The deinstitutionalisation of Mental Health Care cannot occur concurrently with Exploitation.

The publication of WHO's 5 key principles for deinstitutionalisation ensued prior to the LE tragedy yet the GDoH failed to implement any of the recommended measures during the GMHMP. There is a common misconception that deinstitutionalisation is more cost-effective than to provide care for chronic patients in custodial care. Another misconception is that community-based care would alleviate the cost of care for the state as treatment costs will be dispersed to contracted service providers (WHO, 2003). The GDoH was under both these

misconceptions as the main motive for the LE transfers were to reduce the daily cost of healthcare provision from R320 per day at Life Esidimeni to R112 per day for the NGOs.

As indicated by the historical development of psychiatry in South Africa, institutionalisation is more economically effective thus rendering their argument futile. Furthermore, according to the 5th identified principle for deinstitutionalisation, additional financial resources are required so the reasoning provided by the GDoH is inherently flawed. Previous research demonstrated this with reports from the United Kingdom (UK) and the United States of America (USA) indicating that lack of additional resources reduces access to mental health services and therefore limits the individual's capacity to develop, defeating the entire purpose of deinstitutionalisation (WHO, 2003).

It is noteworthy that vulnerability has a correlational relationship with exploitation. David Resnik (2004) identified 3 basic elements that constitute exploitation, namely, harm, disrespect, and injustice – all of which were present in the LE tragedy. Moreover, the profound discrimination, prejudice, and stigma deepened the underlying vulnerabilities faced by the LE patients. As a result, the mental healthcare patients were treated as "sub-human" (Dhai, Gardner and Mahomed, 2021).

Limited resources simply cannot justify the vigorous violation of fundamental human rights. States ought to implement every measure to ensure the enjoyment of economic, social, and cultural rights, such as the right to health. Irrespective of resource availability, fundamental human rights ought to be prioritized, particularly in the case of vulnerable populations (OHCHR, 2008). Throughout history, the exploitation and neglect of people with mental health conditions have resulted in major social and economic gains. (Lund et al., 2011b).

5.5. The Oppression of the Black Mind

Dating back to the colonization of the Cape, mental health care for black people often meant involuntary and long-term admission into custodial facilities. The psychological distress associated with South Africa's socio-cultural, socio-economic, and socio-political context has deemed black people particularly vulnerable (AAAS, 2005). The process of involuntary admission to psychiatric hospitals and the forced participation in medical clinical practices

was a cognitive oppression of the black detainees' fundamental freedoms and an infringement on their right to dignity (Ure, 2009).

As underscored by the historical development of psychiatry in South Africa, the vulnerability of black people in the mental health context was highly attributed to the idea that mentally ill patients should be isolated from society (Makepeace, 1969). Psychiatric institutions built under the Lunacy Laws were used formerly as gaols or military camps (Minde, 1974). Robben Island is an important structure in South Africa's socio-political history that exemplified the isolation and imprisonment of black people under the auspices of mental illness as it was used as both a convict station and lunatic asylum (Gillis, 2012).

The psychological vulnerability of black people is not just associated with mental illness but with mental health as a medical and social discipline. Colonial legislation and apartheid medicine had adverse effects on mental health care provision across black communities in South Africa, specifically in the homelands as there were no black psychiatrists to address the needs of black mental health care patients and users until 1991 (Sukeri, Betancourt and Emsley, 2014). Socio-cultural oppressive tactics, namely through language barriers, were intentionally used to avoid obtaining proper informed consent of black mental health patients who were often forcefully subjected to pharmacological experiments, authorised by social and medical engineers involved in South Africa's Mental Hygiene Movement such as Dunston (Sukeri, Betancourt and Emsley, 2014).

The Psychology Association of South Africa (PASA) expressed its concern over the apartheid state's unethical and violent treatment of black persons detained under apartheid laws. Moreover, PASA emphasized the detrimental damages of widespread violence on the mental health of detained persons (AAAS, 2005). Although psychiatrists working at state prisons were not contracted by the prison system, dual loyalty conflicts were inevitable as they reported to the MoH, under the administration of the Mental Health Act of 1973.

The existence of white supremacy and racial segregation, which has now evolved into classism, diminished the agency of many, if not all, black people and persons of colour affected by the mental health context. The highly polarized racial power struggles observed during the historical development of psychiatry as well as apartheid in South Africa, infringed upon the rights and capabilities of black people and other marginalized persons of colour to

become their self-determined, envisioned selves. The late Black Consciousness leader, Steve Biko, defined this envisioned self as:

> "the condition of no longer being the opposite of someone's definition of themselves" (Biko, 2017).

Furthermore, the envisioned state is described as:

> "a living reality achieved in the social sphere out of the agency of free people" (Biko, 2017).

As mentioned in Chapter 1, section 1.1.4.1, agency is the capacity required of individuals to make intentional decisions. (Dhai, 2019). Agency, dignity, and self-governance establish the principle of autonomy. Intergenerationally, human rights injustices imposed upon the freedom and liberty of black people and persons of colour to provide free and informed consent. A major risk factor for vulnerability is the lack of capacity and ability to provide free and informed consent (Solbakk, 2015). Black people had been denied this liberty for generations, as a result, their vulnerability was exacerbated by the many inhumane acts conducted without their knowledge or consent.

For black people to be truly free, Biko underscored the need to eradicate the polarity between white supremacy and black oppression as the envisioned self is premised on humanistic, inclusionary, and emancipatory principles (Biko, 2017). In the context of mental health, 'Black Consciousness' was and is necessary as an African ethic to underscore the institutionalised oppression of the black mind done through the promulgation of discriminatory laws and the enforcement of prejudiced socio-economic development (Biko, 1976). Furthermore, Black Consciousness is essential for the emancipation of the enslaved mindsets of many institutionalised black people. It can therefore be argued that black people are an inherently and intergenerationally vulnerable group in the context of both mental health and socio-economic development.

5.6. Conclusion

Vulnerability in South Africa's mental health context is mainly attributed to a deep-rooted colonial and socio-economically unjust past combined with modern-day corruption and the maldistribution of resources (SASOP, 2019). The vulnerable mental health context is made worse by intergenerationally-rooted social, cultural, economic, and political tensions that have been exacerbated by the current COVID-19 pandemic. Vulnerable mental health care users and patients in South Africa, particularly black people, have been exposed to exploitative environments that have infringed their socio-cultural and socio-economic rights. Therefore, these marginalised populations ought to be targeted for socio-cultural and socio-economic developmental assistance.

Chapter 6: Prioritizing Universal Access to Mental Health Care

Prior to the birth of South Africa's democracy in 1994, the idea of human rights was not accepted in South Africa for centuries under racism and western colonialism. Historically, access to health care services was based on race and class. Moreover, many laws preceding 1994 were discriminatory towards black people, people of colour and poor people, massively contributing to the current fragmented and inequitable management of mental health care in South Africa (Section27, 2007; Docrat et al., 2019). In response to objective 4, this chapter provides a critical analysis of the conditions required for the provision of mental health care in South Africa's primary health care services.

6.2. Eradicating the negative cycle of Poverty and Mental ill-health

In addition to South Africa's socially unjust past, the realisation of the right to accessible, attainable, acceptable, and quality mental health care has often been hindered by limited access to health care, underdeveloped health systems, and challenges associated with poverty, violence, and communicable diseases (Dhai, Gardner and Mahomed, 2021; van Rensburg and Fourie, 2016). Mental health and poverty interact in a negative cycle, particularly in low-income and middle-income countries (LMICs). Poverty plays a major role in the onset, prevalence, severity, and length of mental health conditions (SADAG, 2020). South Africa's NHI recognizes the impact of poverty on accessing healthcare services and mental health care services (Department of Health, 2017).

South Africa is one of the largest economies on the African continent and is ranked as an upper-middle-income country (UMIC) (Ottersen, Grepin, Henderson, Pinkstaff, Norheim, and Røttinge, 2018). Despite her upper-middle-income socio-economic status, South Africa bears a huge brunt of the burden of mental illnesses with depression, anxiety, substance abuse, and mood disorders ranking the highest (Ottersen et al., 2018). Furthermore, people with mental ill-health have often been neglected and subjected to poor mental healthcare access, severe stigma, and discrimination (Ottersen et al., 2018).

Professor Crick Lund of the Department of Psychiatry and Mental Health at the University of Cape Town (UCT) has emphasized the economic cost associated with neglecting mental health. Lund et al. (2011b) conducted two systematic reviews to assess the effect of alleviating poverty through financial interventions. The first pathway of the Poverty-Mental health cycle is identified via the Social Causation Hypothesis. which stipulates that conditions

of poverty increase the risk of mental illnesses. In South Africa's context, mental illnesses such as depression and PTSD are perpetuated by conditions such as heightened stress, social exclusion, GBV, malnutrition, violence, and trauma, among other social ills (Lund et al., 2011b; SAHRC, 2017). Secondly, the Social Selection/Social Drift Hypothesis claims that people with mental illnesses such as schizophrenia are at increased risk of drifting into poverty through reduced productivity, increased unemployment, discrimination, and stigma. The study further revealed that enhanced economic status correlates with improvements in clinical symptoms, creating a virtual cycle of increasing mental illness (Lund et al., 2011b).

In South Africa's context, geographical influences, historical underpinnings, socio-cultural background, and socio-political factors have perpetuated the negative cycle between poverty and mental health (Dhai, Gardner and Mahomed, 2021). Based on these complex challenges, South Africa experiences worse health outcomes than many lower-income countries (LICs) (Matlala et al., 2018). Approximately 75% of people diagnosed with mental illnesses in South Africa do not have adequate access to mental health services even though mental illnesses significantly influence premature mortality, increased morbidity rates and, reduced economic productivity. To no surprise, it was found that it is mostly poor black South Africans who fall within this treatment gap in mental health (South African Lancet Commission, 2019).

The neglect of mental health care has resulted in major social and economic costs throughout history. In 2013, the SASH estimated total lost earnings of over R40 billion which amounted to 2.2% of South Africa's gross domestic product (GDP) (SADAG, 2020). Severe mental illnesses, namely, major depression and anxiety disorders, account for over R50 000 in lost earnings per affected adults per annum (SADAG, 2020). On the other hand, MHCUs and patients affected by anxiety and depression lose an estimated 27 and 28 days per year, respectively (SADAG, 2020).

The SASH, WHO, NDoH and the Medical Research Council (MRC) have estimated that PTSD affects over 6 million South Africans (SADAG, 2020). Moreover, over 80% of these affected individuals cannot afford private mental health care services. Understandably so, given South Africa's deeply traumatic past. The lack of access to appropriate and affordable mental health care services in South Africa also means that published research and findings on this subject only reflect part of the problem as there are many undiagnosed and untreated cases, despite high mental institution rates in the country (SADAG, 2020).

6.3. Deinstitutionalisation of Mental Health Care

In a shift from oppressive institutionalisation, a major, yet infant, development is the deinstitutionalisation of psychiatric care into community services (Section27, 2018). There has been global acceptance of the notion of deinstitutionalisation of patients with psychosocial disabilities (Freeman 2018). For deinstitutionalisation to occur, the 2014 WHO expert survey identified 5 key principles to implement and monitor deinstitutionalisation of patients with psychosocial and intellectual disabilities, namely:

1. "Community-based services must be in place;
2. The health workforce must be committed to change;
3. Political support at the highest and broadest levels is crucial;
4. Timing is key; and
5. Additional financial resources are needed." (WHO, 2014).

Moreover, the universally agreed upon argument for deinstitutionalisation is to enhance the capabilities of institutionalised patients so they can better integrate into society. Moreover, transferring health services from psychiatric facilities to primary health or community-based care allows patients with psychosocial and intellectual disabilities to lead independent lives and enjoy all their human rights on an equal basis with the rest of society (Freeman, 2018).

The three components of a primary health care approach are as follows:

- Meeting individual and public health needs throughout an individual's life
- Mitigating the overarching determinants of health through transdisciplinary policy and implementation
- Empowering individuals, families, and communities with capacities for independent decision-making with regard to their health (WHO, 2020).

The SAHRC has identified multiple issues across the 22 mental health institutions currently operating in South Africa which, mostly, are in a state of disarray (SAHRC, 2017). Many of these psychiatric institutions in the country have not improved nor progressed much from their colonial development. Deinstitutionalisation has increased in appeal for a variety of reasons. In the South African context, the gaps in mental health care and infrastructure seem to be the main justification for the call and move towards deinstitutionalisation (SAHRC, 2017).

Primary Health Care (PHC) for mental health can be provided using two distinct service models. The first model entails allocating a skilled professional nurse or mental health specialist nurses that cater to individuals with mental health conditions within the PHC clinic. Under this model, these specialist mental health nurses ought to visit the PHC clinic once a month to help manage severe cases as well as provide supervision to the PHC nurses. In addition, a regional psychiatrist would visit once every 3 months and a psychologist to come in 8 hours a week see patients (WHO, 2008). This partnership model for mental health in PHC was piloted in the Mooreesburg District in the Western Cape and, overall, was satisfactory to PHC staff and patients (WHO, 2008).

Alternatively, a service model where all the PHC workers are trained to treat individuals with mental health conditions can be also implemented (WHO, 2008). The severe shortage of mental health specialists and practitioners calls for task-sharing with regard to treating mental health conditions presented at PHC. It is thus important to strengthen the capacity of PHC nurses and staff to gain, not only mental health knowledge, but also confidence to provide the right care for individuals (Petersen, Bhana, Lara et al., 2019). An integrated PHC model for mental health has also been satisfactory, particularly in the Enhlanzeni District in Mpumalanga where there has been a significant improvement in the provision of mental health services since 1994 (WHO, 2008).

It is pertinent to note that deinstitutionalisation is not the mere discharge of patients from psychiatric care; but rather a highly convoluted process that ought to lead to the effective implementation of primary mental health care (WHO, 2003) Neither can deinstitutionalization be implemented in the presence of exploitation, without the respect for dignity (Dhai, Gardner and Mahomed, 2021). In accordance with international standards, PHC ought to be available within 5km of everyone's homes and there ought to be at least one health worker trained in the provision of comprehensive PHC. Moreover, each PHC clinic ought to have a physician or other specialist that can be accessed for consultation support and referral as well as to make periodic visits to address complex mental health issues (WHO, 2008).

Unfortunately, these PHC norms have not been met across country. South Africa's records of failed deinstitutionalisation cited in Chapter 5.3 and 5.4 of this dissertation provide important lessons to consider prior to the implementation of community-based and PHC services.

6.4. Prioritising Primary Mental Health Care through Capacity Development

The Capabilities Approach plays an important role in the provision of PHC and the critique of the social and economic welfare of a community (Venkatapuram, 2007). Furthermore, this theory supports a community and human rights-based approach which recognizes the intrinsic relationship between the right to health care and the right to dignity of all individuals (SAHRC, 2017).

Socio-economic development is indispensable to capacity-building and enhancement in the context of mental health. The UN SDGs, the Alma-Ata Declaration, and the Declaration of Astana underscore the importance of primary health care strengthening to address socio-economic challenges and to achieve equitable and universal health care (Kraef and Kallestrup, 2019).

Many LMICs do not have comprehensive laws addressing the gaps in health care and that protect and promote the rights of people with mental health conditions to ensure UHC and effective participation in the community. While South Africa has progressed towards UHC through the promulgation of the NHI, she struggles to translate policy into action due to poor socio-economic investment (Chisholm et al., 2019). The NHI has been surrounded by controversy and skepticism, particularly from economists who question whether South Africa can sustain the costs of UHC (SAHRC, 2017).

In addition to socio-economic resources, the treatment gaps in the context of mental health are largely attributed to the lack of human resources in the provision of mental health care in South Africa. There is an eminent disparity in the availability of psychologists and psychiatrists across provinces (SADAG, 2020). For example, Limpopo and Mpumalanga have filled 24.2% and 33% of the psychiatric posts, respectively. It is only in the Western Cape where both vacancies have been filled (SADAG, 2020).

As underscored in the previous section, poverty and mental illness are usually closely aligned (World Health Organization, 2003). As a result, factors associated with mental illness classification and diagnosis have increased to include social and economic factors. South

Africa's NHI policy defines the ICD as an international diagnostic tool for epidemiology, health management, and clinical purposes which can be used for many healthcare issues, namely, reimbursement, decision making, resource allocation, monitoring incidence and prevalence of diseases, and other health concerns contextualizing country health systems (Department of Health, 2017). The classification approach described in the NHI is important because it underscores the wider spectrum of factors influencing mental health which are not limited to clinical psychiatric diagnosis. The social and economic considerations in the approach to mental health are important because factors such as abuse, neglect, conflict, socio-economic injustices, and substance use all contribute to the onset and manifestation of psychiatric and neuropsychiatric symptoms (Cirulli, Laviola and Ricceri, 2009). This is especially true for the South African mental health context which is characterised by disproportionate institutionalisation rates (South African Lancet Commission, 2019).

South Africa's 2019 Lancet Commission integrates strategies outlined by the South African Policy Framework which applies a phased approach with regards to the classification, diagnosis, and treatment of mental health conditions. This policy framework recommends psychosocial approaches to mental health as supported by South Africa's MHCA No. 17 of 2002. Furthermore, the MHCA provides the fundamental provisions to promote community-based care, treatment, and rehabilitation of mental health conditions (Draper et al., 2009). Despite this, secondary and tertiary mental health care services have received greater distributive and allocational priority in South Africa. Yet there remains a considerable gap in human resources for specialised mental health care, which has been prioritized more than PHC (SADAG, 2020).

In addition to the MHCA No. 17 of 2002, research has shown that preventing and treating mental health conditions in community and PHC facilities can have positive socio-economic benefits for individuals and households (SADAG, 2020). The MHCU and patient's socio-economic background ought to be given significant consideration in the management and provision of mental health care (Dhai, Gardner and Mahomed, 2021). The 2015 Sustainable Development Goals (SDGs) called for the world to include mental health in socio-economic development plans. To do this, the capabilities of people living with mental illnesses ought to be enhanced so they too can participate in socio-economic activities and development. Lund et al. (2011b) have identified the following interventions for capacity development in the context of mental health:

- Depression-free days from school and work
- Disability scores
- Employment opportunities
- Subsidized costs of health care
- Financial support (Lund et al., 2011b).

In the South African context, the implementation of the NHI aims to mitigate these challenges, namely, through subsiding costs of access to UHC. The NDoH has stated its commitment to ensuring equitable distribution of human resources. However, as observed by the events in the Life Esidimeni tragedy, South Africa's mental health care system is grossly incapacitated and dysfunctional. Furthermore, the lack of prioritization of socio-economic resources for mental health undermines the South African economy. Whilst each aspect of health is important, mental health is yet to receive the priority it deserves in terms of equitable distribution of resources.

6.4. Traditional Holistic Healing to Address Mental Health

South Africa has over 200 000 traditional healers versus approximately 900 psychiatrists in South Africa (Section27, 2007). ATM and indigenous health practices can significantly contribute towards mitigating the disparities in healthcare resource allocation, bridging the low levels of mental health literacy, and addressing disproportionate access to community-based mental health care (Sorsdahl et al., 2009). Despite its benefits, westernisation has largely displaced ATM and indigenous healing practices (Mothibe and Sibanda, 2019).

Concepts such as spirituality, culture and social justice have been at the forefront of African value systems and play an important role in ATM and the provision of holistic healing (Mothibe and Sibanda, 2019). Based on ubuntu and ethics of care, ATM is crucial in achieving holistic health which includes preventative, curative, and palliative care (Mothibe and Sibanda, 2019). Furthermore, ATM and traditional practices have been shown to mitigate the manifestation of psychosocial ailments anticipated to benefit PHC.

Eastern Cape has been at the forefront of human rights injustices in the provision of mental health care. This comes as no surprise considering the historical development of psychiatry in

the Cape (Sukeri, Betancourt and Emsley, 2014; Minde, 1974). Very little has changed in the post-apartheid South African context despite budgetary allocations which ought to support undergraduate medical training that focuses on community care through PHC (Sukeri, Betancourt and Emsley, 2014). In a 1996 report on Health Care in the Eastern Cape, PHC was identified as one of the greatest areas of need mainly attributable to the lack of equitable resource distribution in the province (Health Systems Trust, 1996; Sukeri, Betancourt and Emsley, 2014).

In the hopes of achieving health for all Africans, the WHO Regional Committee for Africa adopted a strategic framework for the African region in the year 2000. This strategic framework optimizes the use of ATM. Member states of the WHO have been strongly encouraged to adopt and implement the strategic framework. The WHO Regional Office for Africa collaborated with the Department of Essential Drugs and Medicines Policy to organize training workshops to aid the implementation mechanisms for the registration of traditional medicines (Mothibe and Sibanda, 2019). The WHO Action Programme on Essential Drugs and Vaccines has deemed drugs for persons with mental illnesses essential, which is also supported by Principle 10 of the UN's MI Principles (World Health Assembly, 1984; Dhai, Gardner and Mahomed, 2021).

In order to reintegrate, conserve and prioritize ATM in South Africa, the African National Congress (ANC) promised to recognise Traditional Health Practitioners (THPs) as integral to the national healthcare system. This promise extended to the healthcare recipients who were assured increased access to health care service options (Mothibe and Sibanda, 2018). However, the realisation of this promise has been delayed due to regulatory challenges. In South Africa, the benefits of ATM were first formally acknowledged in the National Drug Policy (NDP) with the goal of

> "The use of effective and safe traditional medicines at primary level" (National Planning Commission, 2012; Mothibe and Sibanda, 2019)

The Draft National Policy on ATM was journaled in 2008 then conceded as the Traditional Health Practitioners Act (THPA) No. 22 of 2007 but only entered into force in 2013 (Mothibe and Sibanda, 2019). Under the THPA, provisions have been made for traditional healers, namely herbalists, sangomas, traditional midwives, and surgeons, to register and practice officially as a THP recognised under South African law (Mothibe and Sibanda, 2019). There

have been several discussions surrounding the role and benefit of THPs, however, there has been no clear consensus on the way forward (Zingela, van Wyk and Pietersen, 2019). This is largely attributed to the lack of a coherent and 'scientific' code of conduct, resulting in delays in the registration process in the interest of mitigating public risk (Mothibe and Sibanda, 2019).

The delays in this registration process have been associated with a lack of trust in the current government with many THPs fearing the repeated subjugation and oppression of indigenous African healing practices (Mothibe and Sibanda, 2019). Despite these delays, a large majority of African populations still seek ATM, mainly due to its relationship with culture, spirituality, and overall holistic healing (Mothibe and Sibanda, 2019). Legislative and administrative challenges associated with the formalisation and integration of ATM infringe on the right of the healthcare users to seek their preferred method of care or healthcare approach, in direct violation of the Patients' Rights Charter which stipulates:

> "Choice of health services:
>
> Everyone has the right to choose a particular health care provider for healthcare services or a particular health facility for treatment" (Health Professions Council of South Africa (HPCSA), 2008)

However, it further states that the choice ought to fall in line with:

> "prescribed service delivery guidelines" (HPCSA, 2008).

This prescription clause creates a logical fallacy because the freedom to choose is limited by definitions that essentially exclude the preferred choice of care of many Africans. In addition, based on the human right to access health and according to CESCR's framework of a functioning health system, health facilities, resources and services ought to be acceptable by communities and respectful of individual's culture (OHCHR, 2000). Culture, community, and ethics are intricately connected, particularly with regard to the provision of mental health care (Jinger et al., 2008).

To accelerate an ATM framework process, a National Reference Centre for African Traditional Medicine (NRCATM) was established by the former Medicines Control Council (MCC). Currently, South African Health Products Regulatory Authority (SAHPRA) has been overseeing the regulation process for the bulk production of ATMs while minimizing

potential risks to the public (Mothibe and Sibanda, 2019). Furthermore, the NRCATM consists of the NDoH, the Council for Science and Industrial Research (CSIR) as well as the MRC (Mothibe and Sibanda, 2019; SAHPRA, 2020).

While official ethical and safe regulatory guidance is required to ensure the efficacy and safety of health care users, the oppression of ATM and its associated practices in South Africa directly violates ethical, constitutional, and basic human rights (Mothibe and Sibanda, 2019).

The oppression of ATM is premised on the utilitarian notion of protecting the greater good, i.e. society, from harmful and unregulated healthcare practices. However; as demonstrated throughout this dissertation, custodians of health in South Africa have been biased in their definition and provision of ethical health care which has had harmful consequences for mental health care users and patients in the country.

In 2017, the Ethics Alive Alternative Medicine Symposium was held at the Steve Biko Centre for Bioethics which raised ethical issues within health care sciences. The Symposium engaged students, academics and practitioners within the field of health science and introduced different perspectives on medicine whilst simultaneously challenging the scientific basis and principles of biomedicine regarded today as the conventional and universally enforced standard of healthcare (Ethics Alive Alternative Medicine Symposium, 2017). Faith is pertinent to healing, hence the aspect of spirituality in the PHAC definition of mental health (Zuma, 2020; PHAC, 2006). However, historical and current negative perceptions surrounding ATM traditional healing have inhibited people, particularly black people from seeking these indigenous methods of care, thus limiting their right to access health care (Zuma, 2020). Gogo Dineo Ndlanzi, a prominent custodian in the traditional healing context, has actively emphasized the need to integrate biomedical approaches of health with indigenous traditional healing (Zuma, 2020). To eradicate the negative public perception of ATM and traditional healing, Gogo Dineo suggests integration of medications, referrals, and indigenous languages within the context of healthcare provision, including mental health (Zuma, 2020)

As an active member of the WHO, AU and SADC, South Africa has accepted and ratified several commitments to prioritize human rights-based policies, including the integration of African traditional practices into the national health system (Mothibe and Sibanda, 2019). The implementation of these frameworks ought to be done in respect of essential bioethical

principles, namely, ubuntu, respect for autonomy, dignity, and distributive justice. ATM and indigenous healing perspectives require greater consideration in the context of mental health as they echo a biopsychosocial approach to mental health.

6.5. Conclusion

South Africa's geographical influences, historical underpinnings, socio-cultural background, and socio-political factors have exacerbated the negative cycle between poverty and mental health. Health can be defined and approached broadly but it has been fundamentally centred around biomedicine even though it extends far beyond that. While there are notable intersections between mental health and spirituality, the demonization and oppression of ATM has had detrimental effects on the mental health of many individuals in society, particularly black individuals (Mothibe and Sibanda, 2019). The socio-cultural oppression of ATM and indigenous practices has resulted in a fragmented health care system which was limited the rights of many Africans to access universal mental health care. As a result, mental health approaches and structures remain inapt for community rehabilitation and reintegration despite evidence supporting the fact that these approaches are associated with improved mental health and socio-economic outcomes (Gillis, 2012; Burns, 2011).

Chapter 7: Conclusion and Recommendations

The plethora of moral dilemmas confronting South Africa's mental health care system are attributable to the plague of bioethical injustices and the derogation of fundamental human rights. Mental ill-health has posed an intergenerational burden on society and the economy despite recent efforts to improve the delivery of mental health services (Department of Health, 2017). As mentioned in chapter 1.1.5, the social and economic conditions of a society can influence the health outcomes of individuals in a society as well as the right to access healthcare. To improve mental health care and, in-turn, socio-economic development in South Africa, this dissertation proposes the prioritisation of mental health care in community-based services and primary health care, as supported by the NHI plan (Republic of South Africa, 2019).

In the African context, there has been increasing public outcry, mainly against governments, surrounding the recurring human rights violations in the provision of mental health care. The right to access mental health has been intergenerationally oppressed for a large portion of the African continent. Distributive injustice of socio-economic resources is indicative of the colonial and classist construct across the African continent. Despite the existence of mental health organisations, discrimination, stigma, social injustice and unethical practice are at the forefront of mental health care provision in the region.

The over-reliance on flawed utilitarian arguments provided by the state and other custodians of health have had harmful consequences for MHCUs and mentally ill patients. This has exacerbated the vulnerability in the international, regional, and South African mental health context. Furthermore, the intergenerational challenge of dual loyalty faced by HCPs was prominent during slavery, the Mental Hygiene Movement, the historical development of psychiatry in South Africa, and throughout apartheid. Despite democracy and the promulgation of bioethical and human rights protections, recent tragic events in the context of mental health, such as the Life Esidimeni tragedy, confirm that dual loyalty is still a prominent challenge in the provision of quality mental healthcare in Africa.

This dissertation recognizes the lack of African regional mental health associations as a contributing factor to the low mental health advocacy and literacy on the continent. Therefore, this dissertation recommends the widespread establishment of regional mental health organisations to mitigate the discrimination associated with the provision of mental health

care in Africa. Furthermore, these mental health organisations ought to align closely with regional socio-cultural and socio-economic structures.

The right to access mental health care has been established as a socio-economic and socio-cultural human right. The relationship between mental health and socio-economic development has been largely exploited since the enforcement of slavery in South Africa. The remnants of South Africa's colonial past are reflected in the current exploitative and fragmented health care system. Despite the various changes in South Africa's governance since the historical development of psychiatry, discriminatory and segregationist provision of mental health care has been an intergenerational theme. Intergenerational and distributive injustices have negatively skewed the access to and provision of mental health care perpetuating mental health vulnerability in South Africa. Prior to 1994, the vulnerability associated with mental health was mainly attributed to colonialism, racism and apartheid medicine. However, given South Africa's nuanced socio-cultural, socio-economic and socio-political landscape, it is almost impossible to separate class from racism as the bulk of South Africa's socio-economic structure was built upon enslavement of black people and persons of colour. This dissertation recommends a deep level of scrutiny of the current social structures that are still heavily nuanced with oppressive socio-cultural, socio-economic and socio-political undertones.

Normative, human rights-based frameworks that promote ethical treatment of individuals, with an emphasis on vulnerable populations, have become increasingly pertinent for the distribution of fair and equitable UHC. However, despite the current existence of the universally acclaimed legislation, MHCUs and people with mental illnesses remain vulnerable as they do not have equitable access to South Africa's health care and social justice systems. Many psychiatric hospitals in South Africa are outdated, in a state of disrepair and unsuitable for human use. Mental health care patients that have been deemed dangerous to themselves or others in society ought to be institutionalised, with respect to their human and constitutional rights. However, in South Africa's historical context, the determination of mental illness has been driven by biased racial, classist, and even gender-based prejudices resulting in the overmedicalization and criminalization of people with mental health conditions. This structural distortions in the mental health context have laid the foundation for the marginalization of vulnerable groups from society.

The right to access mental health is not an independent right that ought to be addressed in a vacuum. Instead, the right to access mental health care is interdependent on fundamental human rights, namely socio-economic rights. The right to access mental health cannot be realised nor protected without considerable socio-economic investment. Understanding and applying a transdisciplinary approach that intersects various models can contribute towards improving both mental health and socio-economic outcomes. South Africa's move towards deinstitutionalisation did not consider nor provide for the adequate development of community integration and services. Time and resources do not possess any constitutional rights, yet they were prioritized over the basic human rights of the vulnerable mental health care patients and families involved in these tragic events. Based on its intrinsic relationship with the right to dignity, life, and equality, the right to access health ought to be considered a non-derogable right that deserves the highest protection of the law.

The lack of concrete accountability and obligation for government and other custodians of health to uphold and adhere to bioethical and human instruments deem these protections futile. The events witnessed during the Life Esidimeni tragedy where mental health patients were treated as modern-day slaves signified the futility of mental health protections in South Africa. While some justice was sought through the arbitration hearings, a major accountability issue still persists in the South African social justice system. This dissertation, therefore, supports the criminalization of the criminal custodians of health who continue to exploit resources, cause harm and perpetuate the poor state of mental health in South Africa. Just as mental health laws and policies are essential to protect human rights, so too is accountability and robust implementation.

The mental health "pandemic" has not been given this priority despite the detrimental consequences associated with mental health conditions (UN Regional Information Centre for Western Europe (RIC), 2021). Health care planners and providers have been warned to prepare for the spike in psychiatric and other mental health conditions as a result of the COVID-19 pandemic. While the COVID-19 restrictive measures have been justified, they have had detrimental effects on global mental health. In connection with socio-economic development and based on the compounding vulnerabilities associated with the COVID-19 pandemic, this dissertation strongly recommends that the principles of autonomy, compassion, empathy, and ubuntu be applied thoroughly throughout social structures in South Africa and not merely within the public healthcare context. For example, to mitigate domestic

violence, GBV, or general toxic family environments, students and workers ought to be given the freedom to work from community-based social structures, namely, public libraries, school campuses, and other neutral community and social structures. This was accessible before the pandemic but subsequent to the implementation of lockdown restrictions, the majority of entrepreneurs, students, workers, and job seekers have had to work from home to comply with social distance measures. Just as densely populated socio-economic industries can reopen, so too should public facilities and spaces that enable the capacity development of individuals. Physical health is vastly prioritized across the globe as observed by isolation and quarantine measures as well as the emphasized rollout of the COVID-19 vaccine. This dissertation recommends that mental health conditions ought to be given the same priority as physical health conditions.

South Africa's deeply racist, unjust, and socially engineered history did not only affect socio-economic freedoms and rights, but it also suppressed the socio-cultural right of many Africans to practice their culture and spirituality. The western underpinnings in western social practices make it hard to critically analyse their bioethical and social justice systems fairly. This dissertation proposes a shift from consequentialist approaches to mental health care as they often become indistinguishable from social control thus infringing upon individual liberties, specifically the right to dignity. Instead, this dissertation recommends the prioritization of the distributive justice principle, which ought to be applied in the moral management of mental health care. Furthermore, and in an effort too enhance this principle, taking into consideration broader society, this dissertation recommends the prioritization of the principle of Ubuntu in policy decision-making for mental health.

The failure of biomedicine to adequately address the cultural and spiritual dimensions affecting mental illnesses has given rise to significant discourse within the mental health context resulting in detrimental consequences for the mental health and well-being of indigenous individuals. Although many indigenous populations do still consult with traditional healers, the ancestral beliefs of many Africans have been largely oppressed through colonial medicine and unjust laws. This has had toxic effects on the structure of the black culture and family as well as the identity of the black individual. Language is a tool for communication and a vehicle for culture (Matam, n.d.). Given the diverse and multicultural communities we inhabit, socio-economic institutions and structures ought to place an increased emphasis on history, culture, and language to help cultivate culturally conscious and

flexible minds. This increased emphasis is pertinent to decolonize mental health care in South Africa and to conscientize the minds and spirits of systematically oppressed individuals. Individuals ought to be entitled to a society that protects one's health and provides equal opportunities for everyone to enjoy the highest attainable level of health. To address the socio-cultural and socio-economic barriers facing mental health, this dissertation recommends the prioritization, recruitment and retention of black mental health care practitioners and specialists at all levels of health care, with an emphasis on primary health care.

PHC is concerned with community care that addresses holistic health needs, namely physical, mental, social and spiritual well-being. ATM is more than just health; it is healing and can play a major role in the structure of the black family. ATM presents an opportunity to steer away from vertical approaches in the provision of mental health care to a horizontal community approach that is focused on prevention. Thus, traditional healing, of which ancestral healing forms part of, plays an important role in the decolonization and deinstitutionalisation of mental health care in a move towards community-based care. Given the pluralistic nature of bioethical and mental health approaches, to orient oneself within one rigid moral framework can both futile and dangerous process. Therefore, it is essential to have a healthy balance of diverse mental health approaches rooted strongly in African thought and bioethics. To address South Africa's highly polarized approaches to mental health care, this dissertation recommends the culturally competent collaboration between ATM and indigenous healing practices into the current biopsychosocial approaches.

The move towards community-based care requires intentional prioritization and socio-economic investment of additional resources.

Because of the tragic attempts of deinstitutionalisation of psychiatric care in South Africa, this dissertation strongly recommends the prioritization of mental health into primary health care:

- Primary mental health care that prioritizes prevention and direct intervention (Dhai, Gardner and Mahomed, 2021).
- Prioritization that is responsible, accountable, ethical, and just.
- Prioritization that is cognizant of and adheres to the 5 key principles of monitoring deinstitutionalisation

Moreover, prioritization of mental health care into PHC cannot be done in the absence of care, compassion, dignity, and empathy; nor can it occur concurrently with exploitation.

The prioritization of these principles will not only improve the access to and provision of healthcare services but also yield positive socio-economic development for South Africa. Furthermore, mental health care provision ought to be culturally competent and sensitive to the development and liberation of individual capacities within their respective communities. As a result, people can be empowered to reach their self-determined goals; contribute towards South Africa's socio-economic development; and, most importantly, become their best version of their enlightened and envisioned self.

> "Mind is your only ruler, sovereign. The man who is not able to develop and use his mind is bound to be the slave of the other man who uses his mind. Let us work towards the one glorious end of a free, redeemed and mighty nation. Let Africa be a Brightstar among the constellation of nations." – Marcus Mosiah Garvey.

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Appendix 1: Ethics Clearance Certificate

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)

Ref: W-CP-180424-1

24 April 2018

TO WHOM IT MAY CONCERN:

Waiver: This certifies that the following research does not require clearance from the Human Research Ethics Committee (Medical).

Investigator:	**Ms Reabetswe Dithung (student no.708997).**
Supervisor:	**Prof Ames Dhai**
Faculty:	Health Sciences
School:	Clinical Medicine
Department:	Steve Biko Centre for Bioethics
Project title:	**Prioritizing Mental Health Care in Primary Health Care Services: A Bioethical Analysis**
Reason:	Literature Review

Professor Clement Penny

Chair: Human Research Ethics Committee (Medical)

Copy – HREC (Medical) Secretariat: Zanele Ndlovu, Rhulani Mkansi,Iain Burns

Research Office Secretariat: Faculty of Health Sciences, Phillip Tobias Building, 3rd Floor, Office 301, 29 Princess of Wales Terrace, Parktown, 2193 Tel +27 (0)11-717-1252 /1234/2656/2780 Private Bag 3, Wits 2050, email: zanele.ndlovu@wits.ac.za Office email: hrec-medical.researchoffice@wits.ac.za Website:

Appendix 2: Change of Title of Research

UNIVERSITY OF THE WITWATERSRAND JOHANNESBURG

Private Bag 3 Wits, 2050
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Reference: Mrs Sandra Benn
E-mail: sandra.benn@wits.ac.za

06 June 2018
Person No: 708997
TAA

Miss R Dithung
1869 Zone 9
Meadowlands West
Soweto
1852
South Africa

Dear Miss Dithung

Master of Science in Medicine: Change of title of research

I am pleased to inform you that the following change in the title of your Dissertation for the degree of **Master of Science in Medicine** has been approved:

From:	**Prioritizing mental health care in primary health care services: a bioethical analysis**
To:	**The moral imperative to prioritize mental health care in primary health care services: a bioethical analysis**

Yours sincerely

Mrs Sandra Benn
Faculty Registrar
Faculty of Health Sciences

Appendix 3: Turnit in Report

Reabetswe_Dithung_Final_Dissertation_MSc.Med_708997.docx_compressed.pdf