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MENTAL HEALTH CARE FOR WOMEN IN SOUTH AFRICA IN LIGHT OF THE MAPUTO PROTOCOL: ENTRENCHING A GENDER-RESPONSIVE APPROACH IN LEGISLATION

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Abstract

Women with psychosocial disabilities in South Africa are a historically marginalised group whose unique needs and interests were neglected by the systems of mental health care in place during the eras of colonialism and apartheid. A non-essentialist and intersectional understanding of their intensified and multidimensional experiences of vulnerability and disadvantage is applied. This approach is used to frame the analysis of international and regional human rights instruments, primarily the Maputo Protocol, which sets out relevant norms and obligations applicable to mental health care for women in South Africa. The primary lens in this analysis is the right to health, which is read with provisions related to equality and non-discrimination, as set out in the Maputo Protocol and other relevant instruments and interpreted by relevant supervisory bodies. To determine whether the South African system of mental health care sufficiently entrenches a gender-responsive approach in line with international and regional human rights law, an overview of the South African constitutional and legislative framework is provided. While consideration of the right to health and relevant equality jurisprudence reveals that the constitutional framework does allow for an intersectional approach to gender- and disability-based issues, the Mental Health Care Act 17 of 2002 fails to include a gender dimension to the protection and entitlements the Act guarantees. Further analysis of recent South African mental health care jurisprudence also reflects that the approach to mental health care is not appropriately gender-sensitive in a manner that is responsive to the unique vulnerabilities faced by women with psychosocial disabilities. Legislative reform may be needed, as well as increased rigour in the application of intersectionality in constitutional adjudication, to ensure that women with psychosocial disabilities are adequately protected.

Keywords: *mental health care; psychosocial disability; gender equality; intersectionality; South Africa*

1 Introduction

Women with psychosocial disabilities[1] historically have experienced in South Africa significant barriers to accessing mental health care. In the early 1880s, at the Natal Government Lunatic Asylum, female patients of colour who presented as unruly were brought to order by '[dropping] them daily into a large pit specially dug for the purpose'.[2] The Commissioner of Mentally Disordered and Defective Persons, appointed in 1916, reported that £6 was spent to feed one Black female patient for a year at an asylum in Pretoria, in stark contrast with the £25 spent yearly per white male patient at the Valkenberg Asylum in Cape Town.[3] In 1937, the Mental Hospitals Departmental Committee reported a shortage of '452 beds too few for non-European female patients' and observed severe overcrowding in dormitories for women of colour, noting: '[t]hey really make a solid layer of humanity so that there is scarcely room to put a foot between sleeping patients'.[4]

During the colonial and apartheid eras in South Africa, the state's racist policies inflicted severe trauma on women of colour while simultaneously depriving these women of access to quality, ethical care for psychosocial disability.[5] The legislative frameworks in place

1 See F Mahomed 'Stigma on the basis of psychosocial disability: a structural human rights violation' (2016) 32 *South African Journal on Human Rights* 491: 'The term 'person with a psychosocial disability' is now widely utilised … reflecting something of a shift from a discourse that has sought to undermine the rights of individuals who suffer from an intellectual or emotional impairment to one which seeks to promote and protect them.' The term is also widely used by international and regional supervisory institutions. See UN Committee on the Rights of Persons with Disabilities General Comments 1, 5 & 6; UN Committee on the Elimination of Discrimination Against Women (CEDAW Committee), CEDAW General Recommendation 24: art 12 of the Convention (Women and Health), 1999, UN Doc A/54/38/Rev.1 (CEDAW Committee General Recommendation 24); African Commission on Human and Peoples' Rights (ACHPR) 'Principles and Guidelines on the Implementation of Economic, Social and Cultural Rights in the African Charter on Human and Peoples' Rights' (adopted on 24 October 2011) http://archives.au.int/handle/123456789/2063 (accessed 14 August 2024) (2011) (Nairobi Guidelines).

2 J Parle 'Mental illness, psychiatry, and the South African state, 1800s to 2018' (2019) *Oxford Research Encyclopedia* 4.

3 S Swartz 'The black insane in the Cape, 1891-1920' (1995) 21 *Journal of Southern African Studies* 410.

4 J Louw 'Building a mental hospital in apartheid South Africa' (2019) 22 *History of Psychology* 353.

5 World Health Organization 'Apartheid and mental health care' (1977) 6 https://iris.who.int/handle/10665/324941; F Meer & United Nations Centre Against

during the colonial and apartheid eras prioritised issues of public safety, political control, and convenience, with patient welfare being of lesser importance.[6] For example, the Mental Health Act 18 of 1973, in section 1, defined 'patient' as 'a person mentally ill to such a degree that it is necessary that he be detained, supervised, controlled and treated'. The so-called 'rehabilitation' facilities in the various segregated 'homelands' reserved for Black persons were institutions of control rather than care, with then Prime Minister John Vorster stating in 1975 that these institutions would improve the 'physical, mental and moral conditions' of residents, including by 'the fostering of an awareness in regard to the observance of, and the necessity for, the laws of the country'.[7]

With the adoption of the Constitution of the Republic of South Africa, 1996 (Constitution) and the promulgation of the Mental Health Care Act 17 of 2002 (Mental Health Care Act), the intention was to reform the historically oppressive approach to mental health care.[8] However, a key concern is whether women with psychosocial disabilities benefit from such attempts at reform. The majority of women in South Africa have, according to Moultrie and Kleintjes, been plagued by 'chronic social adversity' during their lifetime, attributable in part to gender-based discrimination and oppression.[9] Such adversity can be exacerbated in the event that both gender and disability are relevant factors, as patriarchal beliefs may become intertwined with and reinforce ableism. These attitudes have a severe impact on, for example, women

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Apartheid 'Women in the apartheid society' (1985) 8 https://digitallibrary.un.org/record/98226?ln=en; ES Landis & United Nations Unit on Apartheid 'Apartheid and the disabilities of African women in South Africa' (1975) 3.

6 JK Burns 'Implementation of the Mental Health Care Act (2002) at district hospitals in South Africa: Translating principles into practice' (2008) 98 *South African Medical Journal* at 46; C Ngwena 'The historical development of the modern South African health-care system: From privilege to egalitarianism' in AJ van der Walt (ed) *Theories of social and economic justice* (2009) 188.

7 A Fullerton & United Nations Centre Against Apartheid *Public health problems in apartheid South Africa (1979) 9*.

8 C Lund, D Stein & A Flisher 'Challenges faced by South African health services in implementing the Mental Health Care Act' (2007) 97 *South African Medical Journal* 352; P Nwachukwu & P Segalo *'Life Esidimeni* tragedy: Articulating ecological justice code branding for social care and mental health practice' (2018) 3 *Gender & Behaviour* 11237; D Bilchitz & F Mahomed 'Special cluster: The intersection between mental health and human rights' (2016) 32 *South African Journal on Human Rights* 407.

9 A Moultrie & S Kleintjes 'Women's mental health in South Africa' (2006) *South African Health Review 353*.

who reside in rural areas and are severely affected by both stigma and inequitable resource allocation, as Moultrie and Kleintjes note that 'African rural women are not only poorer in society as a whole but also in their own families'.[10] Burgess conducted a study at a primary health care facility in a rural area, in which the author reports on the experience of a 54-year-old woman seeking care for auditory hallucinations and feelings of depression. A state-appointed medical practitioner refused to confirm her diagnosis for the purposes of qualifying for a disability grant application and informed her that she 'didn't need a grant, she needed a boyfriend'.[11]

In light of the complex historical and current socio-economic context for women with psychosocial disabilities, the objective of this chapter is to assess whether the Mental Health Care Act, read within the South African constitutional framework, sufficiently entrenches a gender-responsive approach in a manner that aligns with the relevant regional and international human rights norms – most notably, the Protocol to the African Charter on Human and Peoples Rights on the Rights of Women in Africa (Maputo Protocol).

It must be acknowledged that, despite urgent calls for deinstitutionalisation,[12] the Mental Health Care Act overwhelmingly focuses on institutionalised care and contains only passing references to community-based mental health care.[13] While the Act is arguably in conflict with the imperative of deinstitutionalisation, it remains the primary mental health care legislation currently in force, which guides the development, interpretation, and implementation of mental health care policy in South Africa. On this basis, the Act has been identified as the focus of this analysis.

To address the overarching objective set out above, this chapter engages with three main research questions. First, what are the international and

10 As above.

11 R Burgess 'Policy, power, stigma and silence: Exploring the complexities of a primary mental health care model in a rural South African setting' (2016) 53 *Transcultural Psychiatry* 727.

12 See, eg, UN Committee on the Rights of Persons with Disabilities (CRPD) General Comment 5 (2017) on living independently and being included in the community, 27 October 2017, CRPD/C/GC/5 (CRPD General Comment 5); UN Committee on the Rights of Persons with Disabilities (CRPD) Guidelines on deinstitutionalization, including in emergencies, 10 October 2022, CRPD/C/5.

13 See, eg, the Mental Health Care Act secs 4(b), 6(8) and 8(2).

regional human rights norms and obligations applicable to women's right to health, specifically mental health care? Second, to what extent does the South African constitutional framework demand, or, alternatively, allow for, an interpretation of the right of access to health care services that is cognisant of the intersecting experiences of discrimination faced by women with psychosocial disabilities? Finally, to what extent does the Act extend protections and entitlements to women with psychosocial disabilities that address their particular vulnerability?

In light of the research objectives and the brief introduction set out above, section 2 of this chapter highlights the need for an intersectional approach to mental health care for women, which must avoid the pitfalls of essentialism in order to be responsive to the lived realities of women with psychosocial disabilities in South Africa. Section 3 sets out the conceptualisations of psychosocial disability adopted in select human rights instruments to frame the discussion of the norms and obligations flowing from the right to health, as entrenched in international and regional human rights law. Building on the work on intersectionality in section 2, section 3 further investigates non-discrimination and equality provisions in international and regional human rights instruments. Section 4 sets out the South African constitutional framework, with a focus on how provision has been made to protect vulnerable groups from discrimination in the constitutional text and in constitutional adjudication. This section further considers socio-economic rights jurisprudence to expound on the content of the right to health. Section 5 considers the provisions of the Mental Health Care Act to determine whether the Act aligns sufficiently with the norms and obligations set out in international and regional law, as discussed in section 3. Key considerations in this analysis include the dominant conceptualisation of psychosocial disability in the Act, the given objectives of the Act and whether non-discrimination is sufficiently entrenched throughout the Act, and whether the provisions of the Act are reflective of a gender-sensitive response to mental health care. Section 5 further develops this understanding with reference to two recent matters where an arbitrator and the South African Constitutional Court broadly analysed the Act and the South African mental health care system.

2 Gender, disability, and intersectionality

Some feminist theories have been criticised for relying on an imagined universal experience of womanhood that is based on the interests and needs of an over-generalised 'essential woman'.[14] Consequently, women whose experiences do not mirror those of the narrowly defined 'essential woman' do not stand to benefit equally from the remedies sought in terms of essentialist theories; for example, women of colour may remain marginalised, or their marginalisation may be exacerbated when legal reform is targeted at improving circumstances as experienced by white women.[15]

In her seminal article on intersectionality, Crenshaw argues that many anti-sexist and anti-racist groups 'quantify' disadvantage by merely tallying the number of vulnerabilities present while failing to engage meaningfully with the lived realities of Black women.[16] In respect of essentialist feminist theories, Harris criticises a 'nuance theory' approach, which views the difference between white and Black women's experiences of hardship as 'a matter of degree' rather than being substantively distinct experiences.[17] Harris further argues that there is very little engagement with Black women's unique experience of marginalisation:

> If things are bad for everybody (meaning white women), then they're even worse for black women. Silent and suffering, we are trotted onto the page (mostly in footnotes) as the ultimate example of how bad things are.[18]

Ngwena borrows from anti-essentialist feminist theories to illustrate that, as with gender discrimination, recognition of both sameness and difference is necessary in combating discrimination on the basis of disability:

14 J Wong 'The anti-essentialism v. essentialism debate in feminist legal theory: The debate and beyond' (1999) 5 *William & Mary Journal of Race, Gender, and Social Justice* 275; K van Marle & E Bonthuys 'Feminist theories and concepts' in E Bonthuys & C Albertyn (eds) *Gender, law and justice* (2007) 26.

15 KT Bartlett 'Gender law: After twenty-five years' (2020) 27 *Duke Journal of Gender Law & Policy* 3.

16 K Crenshaw 'Demarginalizing the intersection of race and sex: A Black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics' (1989) 139 *University of Chicago Legal Forum* 140.

17 Wong (n 14) 284.

18 A Harris 'Race and essentialism in feminist legal theory' (1990) 42 *Stanford Law Review* 595.

> To be responsive to the equality aspirations of disabled people, substantive equality should seek to be multidimensional rather than rigid in order to be responsive to the universal as well as the particular.[19]

Ngwena's criticism of a 'rigid' approach in disability studies links to Harris' argument above, namely that discrimination faced by Black women is falsely seen as no more than an intensified form of discrimination instead of its own unique configuration of disadvantage. Watermeyer and Swartz similarly criticise approaches in which disability is viewed purely as a 'magnifier or nuance' in the experience of, for example, oppression on the basis of gender.[20] Consider the following extract from a South African White Paper on the Rights of Persons with Disabilities: '[p]ersons with disabilities face *different levels* of discrimination and exclusion – in particular, women and girls with disabilities may face *double discrimination* based on both disability and gender'.[21] This approach fails to acknowledge the unique form of discrimination experienced at the intersection of gender and disability,[22] as evidenced by the fact that the term 'double discrimination' is also employed elsewhere in the White Paper to describe the experiences of persons with disabilities living with HIV.[23]

This extract brings to mind the concept of 'lazy' intersectionality put forth by Watermeyer and Swartz, who warn that a bare mention of the fact that gender and disability function as intersecting grounds of disadvantage should not be mistaken as 'some sort of real knowledge about disability itself'.[24] While a large number of persons with disabilities may experience discrimination resulting from, for example, a specific policy decision, the nature and extent of the impact will not be uniform.[25]

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19 C Ngwena 'Developing juridical method for overcoming status subordination in disablism: The place of transformative epistemologies' (2014) 30 *South African Journal on Human Rights* 298.

20 B Watermeyer & L Swartz 'Disability and the problem of lazy intersectionality' (2023) 38 *Disability and Society* 363.

21 South African Department of Social Development White Paper on the Rights of Persons with Disabilities Government Notice 230, GG 39792, 9 March 2016 23. My emphasis.

22 I Grobbelaar-Du Plessis 'African women with disabilities: The victims of multilayered discrimination' (2007) 22 *South African Public Law* 407.

23 Department of Social Development (n 21) 87.

24 Watermeyer & Swartz (n 20) 364.

25 J Mulvany 'Disability, impairment or illness? The relevance of the social model of disability to the study of mental disorder' (2000) 22 *Sociology of Health & Illness* 586; F Bhabha 'Disability equality rights in South Africa: Concepts, interpretation

Persons with disabilities do not constitute a homogeneous collective.[26] A further key point is that persons with disabilities are not an 'ahistorical group'.[27] It must, therefore, be borne in mind that the lived realities of women with psychosocial disabilities in South Africa are shaped not only by their gender and disability, but also by their experience in enduring the apartheid era and navigating its pervasive legacy.[28]

Where such multi-faceted identities are at play, Clutterbuck warns that victims of discrimination may have no choice but to abandon elements of their claims – in effect, elements of their identities – when approaching the courts, as existing jurisprudence does not accommodate complex claims that are based on multiple intersecting grounds of discrimination.[29] Lorde, as quoted by Harris, recounts the constant pressure experienced, as a queer Black woman, 'to pluck out some one aspect of myself and present this as the meaningful whole, eclipsing or denying the other parts of self'.[30]

In light of the discussion in this part, the following three broad questions will be applied to guide the evaluation of the South African constitutional and legislative framework as a means of incorporating an intersectional and anti-essentialist perspective. First, does the framework acknowledge that a more complex and compounded form of vulnerability exists where gender and disability intersect? Second, does the framework reflect any attempt to understand what that complex state of vulnerability could entail within the South African historical and socio-economic context? Third, if so, does the framework accordingly afford appropriate additional protections and entitlements to women with psychosocial disabilities? These three questions will be applied in conjunction with the norms and obligations derived from international

and the transformative imperative' (2009) 25 *South African Journal on Human Rights* 233.

26 M Heap, T Lorenzo & J Thomas ''We've moved away from disability as a health issue: it's a human rights issue': reflecting on 10 years of the right to equality in South Africa' (2009) 24 *Disability and Society* 861.

27 K Mohamed & T Shefer 'Gendering disability and disabling gender: Critical reflections on intersections of gender and disability' (2015) 29 *Agenda* 5.

28 S Kleintjes & M Schneider 'History and politics of mental health policy and care in South Africa' (2023) 3 *SSM – Mental Health* 2.

29 A Clutterbuck 'Rethinking Baker: A critical race feminist theory of disability' (2015) 20 *Appeal: Review of Current Law and Law Reform* 62.

30 Harris (n 18) 586.

and regional human rights instruments, as discussed in the following part.

3 Mental health care for women: International and regional human rights norms and obligations

3.1 Introduction

While the right to health has been adopted as the primary lens for this chapter, both health and disability are affected by a range of determinants and understood in relation to complex and ever-evolving social norms.[31] The right to health, further, does not operate in isolation, as Lorde notes: '[t]here is no thing as a single-issue struggle because we do not live single-issue lives'.[32] Consequently, this part bases its analysis primarily on the right to health, but incorporates other relevant provisions found in international and regional human rights law – most notably, provisions which extend specific or additional protections on the basis of gender and/or disability.

Two provisions in the Maputo Protocol anchor the analysis in this section: Article 14[33] in respect of the right to health and article 23[34] on protecting women with disabilities. While these provisions in the Maputo Protocol are the focal point of this chapter, this part also considers the equivalent or corresponding provisions in other

31 K Moyo 'Realising the right to health in South Africa' (2016) *Socio-economic Rights – Progressive Realisation?* 31.

32 Quoted in M Bailey & I Mobley 'Work in the intersections: A Black feminist disability framework' (2019) 33 *Gender and Society* 20.

33 Maputo Protocol art 14 provides:
'1. States Parties shall ensure that the right to health of women, including sexual and reproductive health is respected and promoted.
2. States Parties shall take all appropriate measures to: Provide adequate, affordable and accessible health services, including information, education and communication programmes to women especially those in rural areas.'

34 Maputo Protocol art 23 provides:
'that States Parties undertake to:
(a) Ensure the protection of women with disabilities and take specific measures commensurate with their physical, economic and social needs to facilitate their access to employment, professional and vocational training as well as their participation in decision-making;
(b) Ensure the right of women with disabilities to freedom from violence, including sexual abuse, discrimination based on disability and the right to be treated with dignity'.

international and regional human rights instruments. At international level, relevant instruments include the International Covenant on Economic, Social and Cultural Rights (ICESCR),[35] the United Nations Convention on the Rights of Persons with Disabilities (Disability Convention),[36] and the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW),[37] while the key regional sources include the African Charter on Human and Peoples' Rights (African Charter),[38] and the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Persons with Disabilities in Africa (African Disability Protocol).[39] This section consequently acknowledges the interplay between the Maputo Protocol and these instruments and the interpretation thereof by various supervisory bodies and institutions.

3.2 Conceptualising psychosocial disability

How psychosocial disability is understood will determine whether there is a genuine commitment to realise the rights of women with psychosocial disabilities as a matter of urgency. Conceptualisations aligned with the medical model ascribe the hardship experienced by persons with disabilities to their supposedly defective body.[40] When there is a failure to acknowledge that disadvantage is not the result of some individual defect or inability, instead of a systemic issue, states parties can more easily 'depoliticise' the issues raised by women with psychosocial disabilities, including issues such as insufficient resource allocation.[41] Practically speaking, states parties can then divest themselves of their constitutional or statutory obligations towards persons with disabilities. In this respect, stigma against persons with disabilities is highly dangerous, as it can

35 Article 12 on the right to health.
36 Article 6 on the rights of women with disabilities; art 25 on the right to health.
37 Article 12 on health care; art 14 on access to health for rural women.
38 Article 16 on the right to health; art 18(3) on special protection of women; art 18(4) on special protection of persons with disabilities.
39 Article 17 on the right to health; art 27 on women and girls with disabilities.
40 For a comparison of the medical, social, and human rights-based models of disability, see T Degener 'Disability in a human rights context' (2016) 5 *Laws* 1-24. These models have been applied to disability in the broader sense, and to psychosocial disabilities in particular. See, eg, Mulvany (n 25) 582-601; P Beresford 'Thinking about 'mental health': Towards a social model' (2002) 11 *Journal of Mental Health* 581-584.
41 M Pieterse 'Health care rights, resources and rationing' (2007) 124 *South African Law Journal* 517.

'dehumanise the sufferer and, by implication, supposedly render human rights inapplicable'.[42]

While the Maputo Protocol contains a provision titled 'Special Protection of Women with Disabilities',[43] the term 'disability' is not defined in this instrument. While neither the Disability Convention nor the African Disability Protocol contains a definition of 'disability', these two instruments contain similar non-exhaustive lists of 'persons with disabilities', which include 'those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others'.[44] As an illustration, the UN Committee on the Elimination of all Forms of Discrimination Against Women (CEDAW Committee) has, in its writings on the right to health, identified disabilities that are prevalent among women, including postpartum depression and eating disorders, as well as late-life degenerative conditions such as dementia.[45]

A further key point is that disability is 'an evolving concept', as noted in paragraph (e) of the Preamble to the Disability Convention. As observed by the Special Rapporteur on the Right to Health, persons with disabilities may find that specific terminology resonates with them – for example, some prefer to distinguish between impairment and disability,[46] while others adopt terms that are seen to be empowering, such as 'mental health survivor'.[47] The Special Rapporteur on Disability further notes that 'it is important to acknowledge that the notion of impairment varies throughout history, cultures and societies, reflecting the values and norms of a specific time and place'.[48]

42 Mahomed (n 1) 492.
43 Maputo Protocol art XXII.
44 Disability Convention art 1; African Disability Protocol art 1. One distinction between the two provisions is that the phrase 'long-term' is omitted in the latter instrument.
45 CEDAW Committee General Recommendation 24 (n 1) paras 12(c) & 24.
46 See, eg, Beresford (n 40) 223-224; Bhabha (n 25) at 223.
47 UN Human Rights Council (HRC) Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health (15 April 2020) UN Doc A/HRC/44/48 para 4 (Report of the Special Rapporteur on Physical and Mental Health (2020)).
48 UN Human Rights Council (HRC) Report of the Special Rapporteur on the Rights of Persons with Disabilities (16 July 2018) UN Doc A/73/161 para 6.

The dominant attitudes towards women with psychosocial disabilities – in law-making bodies and in communities – will determine whether they are indeed identified as a group deserving of additional resources or special protection without being considered 'objects of welfare and charity'.[49] Harmful disablist and sexist stereotypes faced by women with psychosocial disabilities include what the Special Rapporteur on the Right to Health referred to as the 'medicalization of women's feelings and behaviour'.[50] On the other end of the spectrum, the Committee on Economic, Social and Cultural Rights (CESCR) has raised the concern that the intersectional discrimination faced by women with disabilities is not sufficiently recognised as persons with disabilities 'are sometimes treated as genderless human beings'.[51] Of relevance to these concerns is article 5 of the Maputo Protocol, which imposes an obligation on states parties to 'prohibit and condemn' all harmful practices, which article 1(g) defines as 'all behaviour, attitudes and/or practices which negatively affect the fundamental rights of women …' Article 11 of the African Disability Protocol similarly prohibits 'harmful practices', while providing more detailed examples of prohibited practices:

> States Parties shall take all appropriate measures and offer appropriate support and assistance to victims of harmful practices, including legal sanctions, educational and advocacy campaigns, to eliminate harmful practices perpetrated on persons with disabilities, including witchcraft, abandonment, concealment, ritual killings or the association of disability with omens.

Consequently, when evaluating the South African constitutional and legislative framework applicable to mental health care, a key consideration will be whether the framework aligns with the conceptualisations of disability set out above. Most notably, disability must not be framed in terms of the medical model, and the role of history, communities, and cultural practices in shaping the experience of disability must be acknowledged.

49 Degener (n 40) 13.
50 Report of the Special Rapporteur on Physical and Mental Health (2020) (n 47) para 59.
51 UN Committee on Economic, Social and Cultural Rights (CESCR) General Comment 5: Persons with disabilities, 9 December 1994, E/1995/22 para 19.

3.3 Normative standards applicable to mental health care for women

While not constituting 'a right to be healthy',[52] the right to health encompasses a wide range of protections and entitlements. Bodies such as the CESCR, the African Commission on Human and Peoples' Rights (African Commission) and the United Nations Committee on the Rights of Persons with Disabilities (CRPD Committee) have clarified the normative content of the right to health under international and regional law by identifying a number of interdependent elements.

The CESCR, in its general comment on the right to health, makes use of the 'AAAQ' framework, which identifies 'availability', 'accessibility', 'acceptability', and 'quality' as crucial facets of the right to health.[53] While the Disability Convention similarly identifies availability, accessibility, and acceptability as being at the core of the realisation of the right to health, the CRPD Committee adds that these attributes must be realised 'for persons with disabilities in their communities'.[54]

At a regional level, the Nairobi Guidelines[55] serve as a point of departure, in which the African Commission sets out four focal points for the realisation of socio-economic rights, namely: 'availability', 'adequacy', 'physical and economic accessibility' and 'acceptability'.[56] The African Commission specifically notes, in paragraph 3(c) of the Guidelines, that states parties must be responsive to the circumstances of 'vulnerable and disadvantaged groups, for whom special measures may be necessary'.

The African Commission has also elaborated on the right to health in the specific context of the Maputo Protocol, which provides in article XIV(2)(a), that health care services must be 'adequate, affordable and accessible'. In its General Comment 2 of the African Commission on

52 UN Committee on Economic, Social and Cultural Rights (CESCR) General Comment 14: The Right to the Highest Attainable Standard of Health (Art 12) (2000) E/C.12/2000/4 para 8 (CESCR General Comment 14); Nairobi Guidelines (n 1) para 61.
53 CESCR General Comment 14 (n 52) para 12.
54 CRPD General Comment 5 (n 12) para 89. The Committee notes that these attributes must be present 'in hospitals as well as at home', as part of the right to health in art 26. These obligations are thus grounded in art 26, and not in art 19, 'Living independently and being included in the community'.
55 Nairobi Guidelines (n 1).
56 Nairobi Guidelines (n 1) para 3.

article 14 of the Maputo Protocol,[57] the African Commission focuses primarily on sexual and reproductive rights. However, the normative standards identified can be applied to the right to health in the broader sense, including mental health care, including the following dimensions: 'availability, financial and geographical accessibility' and 'quality', all of which must apply 'without any discrimination'.[58]

3.4 Equality and non-discrimination in the provision of health care

While there are some variations across the different instruments and supervisory bodies in the formulation of the normative elements of the right to health, these largely correspond in substance to the CESCR's AAAQ framework. Notably, the above instruments all require that mental health care be provided without discrimination. In *Purohit and Moore v the Gambia* (*Purohit*),[59] the African Commission acknowledged the severe resource constraints faced by African countries, which frustrate the realisation of the right to health, including for persons in need of mental health care. In finding a violation of the right to health in article 16 and the rights of 'the aged and the disabled' in article 18(4), the Commission held:

> Therefore, having due regard to this depressing but real state of affairs, the African Commission would like to read into Article 16 the obligations on part of States party to the African Charter to take concrete and targeted steps, while taking full advantage of its available resources, to ensure that the right to health is fully realised in all its aspects without discrimination of any kind.[60]

The African Commission has further, in its commentary on the right to health in the Maputo Protocol, imposed an obligation on the state to eradicate the systems that 'promote and perpetuate gender-based inequality', including 'cross-cutting forms of discrimination' that are entrenched in legal and policy frameworks.[61] In this respect, it is crucial

57 African Commission General Comment 2 on Article 14(1)(a), (b), (c) and (f) and Article 14(2)(a) & (c) of the Protocol to African Charter on Human and Peoples' Rights on the Rights of Women in Africa, adopted during the 54th ordinary session of the African Commission held in Banjul, The Gambia, 22 October-5 November 2013 (African Commission General Comment 2).
58 African Commission General Comment 2 (n 57) para 22.
59 (2003) AHRLR 96 (ACHPR 2003).
60 *Purohit* (n 59) para 84.
61 African Commission General Comment 2 (n 57) para 22.

to acknowledge, as the CRPD Committee has, that legislative and policy frameworks that are seemingly 'neutral', may have a discriminatory effect for failing to provide sufficient protection for disadvantaged and vulnerable groups.[62] The CESCR has similarly cautioned that inequality may be maintained or even be aggravated by supposedly gender-neutral frameworks.[63] The CESCR further, in developing the AAAQ framework, specifically recommended that states parties 'integrate a gender perspective' into the frameworks governing health care.[64] The CEDAW Committee further compels states parties to report on how their system of health care 'addresses distinctive features and factors that differ for women in comparison to men'.[65] The CESCR has also commented that the particular impact of 'cumulative discrimination' on individuals who have multiple marginalised identities can most often be combatted only through increased and targeted allocation of resources to those vulnerable groups.[66]

4 The South African constitutional framework

The Constitution of the Republic of South Africa, 1993 (interim Constitution) introduced, in its Postamble, the notion of a constitution as 'a historic bridge between the past of a deeply divided society … to a future founded on the recognition of human rights'. It further stated that human rights must be guaranteed 'for all South Africans, irrespective of colour, race, class, belief or sex'. Disability is not expressly included, in which respect the final Constitution improves substantially, as section 9(3) thereof expressly includes disability, as well as race and gender, as prohibited grounds of discrimination. The Constitutional Court has adjudicated on the right to equality on numerous occasions, including

62 UN Committee on the Rights of Persons with Disabilities (CRPD) General Comment 3 (2016), Article 6: Women and girls with disabilities, 25 November 2016, UN Doc CRPD/C/GC/3 para 17(e) (CRPD General Comment 3).

63 UN Committee on Economic, Social and Cultural Rights (CESCR) General Comment 16: The equal right of men and women to the enjoyment of all economic, social and cultural rights (2005) E/C.12/2005/3 para 8 (CESCR General Comment 16).

64 CESCR General Comment 14 (n 52) para 20.

65 CEDAW Committee General Recommendation 24 (n 1) para 12.

66 UN Committee on Economic, Social and Cultural Rights (CESCR) General Comment 20: Non-discrimination in Economic, Social and Cultural Rights (2009) E/C.12/GC/20 para 17.

National Coalition for Gay and Lesbian Equality v Minister of Justice (*National Coalition*), in which Sachs J noted:

> What the Constitution requires is that the law and public institutions acknowledge the variability of human beings and affirm equal respect and concern that should be shown to all as they are. At the very least, what is statistically normal ceases to be the basis for establishing what is legally normative.[67]

While section 9(2) does prohibit the state from unfairly discriminating against anyone on 'one or more grounds', the text of the Constitution does not expressly account for the compounded discrimination that is experienced – in the present case – at the intersection of gender, disability and race. However, the Constitutional Court has interpreted section 9 through an intersectional lens, most notably in *Mahlangu v Minister of Labour* (*Mahlangu*).[68] In considering domestic workers' multilayered experience as members of a group who have historically been disadvantaged on grounds of race, class and gender, Victor J states:

> Adopting intersectionality as an interpretative criterion enables courts to consider the social structures that shape the experience of marginalised people. It also reveals how individual experiences vary according to multiple combinations of privilege, power, and vulnerability as structural elements of discrimination.[69]

Victor J further notes that the intersection of multiple marginalised identities creates a 'qualitatively different experience'.[70] In other words, the various facets of a person's identity do not each have a discrete, compartmentalised impact on that individual's lived reality, as also argued by Sachs J in *National Coalition*.[71] While the Court's express acknowledgement of multilayered discrimination represents a crucial milestone, this recognition must also be translated into practice beyond the courtroom to impact the lived realities of women with psychosocial disabilities. Bhabha illustrates this point with reference to the transformative mandate entrenched in the Constitution:

> In other words, the transformation imperative likely demands more than lofty pronouncements about the equality and dignity of disabled persons. It also

67 1999 (1) SA (CC) para 134. Although the court was not called upon in this instance to adjudicate directly on disability-related issues, the quoted extract has been applied in the realm of disability studies, including in Ngwena (n 19) 282.
68 2021 (2) SA 54 (CC).
69 *Mahlangu* (n 68) para 79.
70 *Mahlangu* (n 68) para 8.
71 *National Coalition* (n 67) para 113; *Mahlangu* (n 68) para 77.

> necessitates measures not only to remedy discrimination but also to re-orient the underlying societal structures that contribute to systemic material deprivation and to the exclusion of people with disabilities.[72]

The Constitution enshrines the right of access to health care services in section 27(1)(a). Section 27(2) further provides: 'The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights.' Three qualifiers are entrenched in section 27(2): reasonableness, progressive realisation, and the availability of resources. The first of these three qualifiers relies on the 'reasonableness review' model, applied in socio-economic rights jurisprudence to evaluate the method adopted by the state to realise a socio-economic right – specifically, whether that method is 'reasonably capable of facilitating the realisation of the rights in question'.[73] The state nevertheless has a discretion in the programme it develops to realise socio-economic rights, as whether 'other more desirable or favourable measures' exist is not something the Constitutional Court has to consider in socio-economic rights adjudication to which the state is a party.[74] Even so, the court considers a range of criteria when considering the reasonableness of socio-economic rights programmes – applying these to the programme as it was developed as well as to the programme as implemented.[75]

A key criterion is that the state's programme aimed at realising a constitutional right must reflect that due consideration was given to the circumstances of vulnerable groups, as noted by the Constitutional Court in *Government of South Africa v Grootboom* (*Grootboom*):

> To be reasonable, measures cannot leave out of account the degree and extent of the denial of the right they endeavour to realise. Those whose needs are the most urgent and whose ability to enjoy all rights therefore is most in peril, must not be ignored by the measures aimed at achieving realisation of the right.[76]

72 Bhabha (n 25) 241.
73 S Liebenberg 'Needs, rights and transformation: Adjudicating social rights' (2006) 17 *Stellenbosch Law Review* 22.
74 *Government of the Republic of South Africa v Grootboom* 2001 (1) SA 46 (CC) para 41; *Khosa v Minister of Social Development; Mahlaule v Minister of Social Development* 2004 (6) SA 505 (CC) para 48.
75 *Khosa* (n 74) para 42.
76 *Khosa* (n 74) para 44.

The appropriate allocation of resources for such a programme is a further key criterion.[77] To include 'within available resources' as a qualifier for the constitutional right of access to health care services is an acknowledgement that resource constraints are a key concern, as also noted by the African Commission referred to above. For example, the South African Constitutional Court has acknowledged, in the context of the right to health: 'There are many pressing demands on the public purse'.[78] However, the Constitutional Court noted two further key points in respect of resource allocation for socio-economic rights. First, that the state has an obligation to 'differentiate between categories of people and to prioritise'.[79] This duty ties in with the earlier passage from *Grootboom,* on responsiveness to vulnerability.[80] Second, the state cannot evade its constitutional obligations simply because it has failed to budget appropriately, 'according to a mistaken understanding of its constitutional and statutory obligation'.[81]

Further reasonableness criteria include ensuring that responsibilities are clearly allocated to various spheres of government and that the programme in question is well-coordinated, comprehensive, and coherent.[82] A further promising mechanism, most often applied in the context of housing rights, is that of 'meaningful engagement', which was developed extensively in *Occupiers of 51 Olivia Road, Berea Township and 197 Main Street, Johannesburg v City of Johannesburg*.[83] Meaningful engagement between the state and rights bearers serves a dual purpose. First, the process ensures that the state is made aware of the interests and concerns of rights bearers, resulting in socio-economic programmes

77 *Khosa* (n 74) para 39.
78 *Treatment Action Campaign v Minister of Health* 2002 (5) SA 721 (CC) para 37.
79 *City of Johannesburg Metropolitan Municipality v Blue Moonlight Properties 39 (Pty) Ltd* 2012 (2) SA 104 (CC) para 86.
80 *Grootboom* (n 74) para 44.
81 *Blue Moonlight* (n 79) para 74; D Moseneke *In the Arbitration between: Families of Mental Health Care Users Affected by the Gauteng Mental Marathon Project and National Minister of Health of the Republic of South Africa, Government of the Province of Gauteng, Premier of the Province of Gauteng, MEC for Health: Province of Gauteng before Justice Dikgang Moseneke* (2018) para 41 (*Marathon Project Arbitration*).
82 *Grootboom* (n 74) paras 39, 40-41.
83 2008 (3) SA 208 (CC). See also *Residents of Joe Slovo Community, Western Cape v Thubelisha Homes* 2010 (3) SA 454 (CC).

more responsive to their needs.[84] Second, meaningful engagement is an empowering process, as it recognises that rights claimants are 'active stakeholders rather than just passive recipients of socio-economic goods and services'.[85] However, a troubling trend in respect of participatory processes in the context of mental health care is that the state adopts what has been termed a 'hit and run' tactic and engages only superficially with mental health care users and their representative organisations.[86]

Progressive realisation is included in section 27 to act as 'necessary flexibility device', cognisant of the various challenges and constraints faced by the state in its attempts to realise socio-economic rights. However, progressive realisation still requires 'deliberate, concrete' steps to be taken with the aim of achieving the full realisation of the right 'as expeditiously as possible'.[87] In *Grootboom*, the Constitutional Court also noted that progressive realisation would entail extending access to goods and services 'not only to a larger number of people but to a wider range of people as time progresses'.[88] Consequently, progressive realisation requires decision-making processes, whether legislative, policy-based or budgetary, to be forward-looking.[89]

5 The South African Mental Health Care Act

In this part, the South African legislative framework governing mental health care is analysed to determine whether there is alignment with the international and regional norms and obligations set out above in

84 *Olivia Road* (n 83) para 15; L Chenwi 'Meaningful engagement in the realisation of socio-economic rights: the South African experience' (2011) 26 *South African Public Law* at 155.

85 Chenwi (n 84) 129.

86 See, eg, S Kleintjes, C Lund & L Swartz 'Barriers to the participation of people with psychosocial disability in mental health policy development in South Africa: A qualitative study of perspectives of policy makers, professionals, religious leaders and academics' (2013) 13 *International Health and Human Rights*; S Kleintjes, C Lund, L Swartz, A Flisher & The MHAPP Research Programme Consortium 'Mental health care user participation in mental health policy development and implementation in South Africa' (2010) 22 *International Review of Psychiatry* 568-577.

87 CESCR General Comment 3 para 6; CESCR General Comment 14 (n 52) para 39.

88 *Grootboom* (n 74) para 45.

89 D Bilchitz 'Fundamental rights as bridging concepts: Straddling the boundary between ideal justice and an imperfect reality' (2018) 40 *Human Rights Quarterly* 136.

section 3. As a point of departure, the dominant conceptualisation of psychosocial disability in the Act is considered to determine whether the Act itself entrenches a substantive equality approach to disability. Thereafter, this part considers provisions in the Act that relate to non-discrimination and gender to analyse the Act's approach – if any – to the intersectional discrimination faced by women with psychosocial disabilities. Finally, after having considered the text of the Act, this section turns to two matters before an arbitrator and the Constitutional Court, respectively, which represented opportunities to reflect on and interpret the provisions of the Act to further develop our understanding of the protections and entitlements afforded therein.

5.1 Conceptualisations of psychosocial disability

The definitions and interpretative guides included in legislation can assist in developing our understanding of the protections and entitlements afforded by that legislative instrument. As noted in sections 2 and 3 above, it is necessary to avoid essentialising gender and disability. Rather, as in the case law discussed in section 4, an intersectional approach is needed for vulnerable groups such as women with psychosocial disabilities to be protected optimally. This part consequently considers whether psychosocial disability is understood in the Act in a manner that acknowledges multidimensional vulnerability, including the specific vulnerability to harmful practices faced by women with psychosocial disabilities.

The Act does not use the term psychosocial disability and refers, in its Preamble, to 'mental disorders or mental disabilities'. Further insight into the theoretical underpinnings of the Act can be gained with reference to section 1, which defines key terms, including 'mental illness', being: 'a positive diagnosis of a mental health related illness in terms of accepted diagnostic criteria made by a mental health care practitioner authorised to make such a diagnosis'.[90] The term 'mental health status' shows greater promise than this medicalised approach, being defined as: 'the level of

90 The term 'mental illness' is used primarily in the parts of the Act that concern prisoners with psychosocial disabilities. See, eg, sec 51 ('Care, treatment and rehabilitation of prisoners with mental illnesses in prison'); sec 52 ('Magisterial enquiry concerning transfer to designated health establishments'); sec 56 ('Recovery of mental health status of mentally ill prisoners').

mental well-being of an individual as affected by physical, social and psychological factors and which may result in a psychiatric diagnosis'. The term which sees the most frequent use in the Act, 'mental health care user', is defined as 'a person receiving care, treatment and rehabilitation services or using a health service at a health establishment aimed at enhancing the mental health status of a user'.

These terms improve somewhat on terminology employed in colonial and apartheid era instruments – such as 'lunatics' and those deemed an 'idiot or person of unsound mind' in terms of the Lunacy Act 35 of 1891, or 'imbeciles' or 'socially defective' in terms of the Mental Disorders Act 38 of 1916. However, the Preamble and definition provision of the present Act does not unequivocally locate the provisions within an anti-essentialist perspective, grounded in recognition of the diverse needs of persons with psychosocial disabilities and the unique vulnerability experienced by those who find themselves at the intersection of a number of marginalised identities. For example, the prominent reference to vulnerability in the Preamble to the Act is the following:

> Recognising that the person and property of a person with mental disorders or mental disabilities, may at times require protection and that members of the public and their properties may similarly require protection from people with mental disorders or mental disabilities.

The Act, therefore, in its definitional and interpretative guidelines, does not set down a clear or solid foundation for an intersectional and gender-sensitive approach to mental health care.

5.2 Non-discrimination, gender, and intersectionality in the Act

In addition to the Preamble and the definitions in section 1, section 3, titled 'Objects of the Act', guides the interpretation of the Act.[91] This section contains no express reference to non-discrimination or the need to consider intersecting disadvantage in extending additional protections to women with psychosocial disabilities. Even section 10, which is titled 'Unfair discrimination', deals only with discrimination against a mental

91 See sec 2(1): Interpretation. Section 3 provides, inter alia: 'The objects of this Act are to (a) regulate the mental health care in a manner that (i) makes the best possible mental health care, treatment and rehabilitation services available to the population equitably, efficiently and in the best interest of mental health care users within the limits of the available resources'

health care user 'on the grounds of his or her mental health status' and provides for mental health care users to receive care 'according to standards equivalent to those applicable to any other health care user'. The Preamble similarly only contains a passing reference to discrimination, in which it is acknowledged that the Constitution 'prohibits against unfair discrimination of people with mental or other disabilities'.

Section 11, which is titled 'Exploitation and abuse', creates an obligation in section 11(1)(a) on persons and establishments providing mental health care to take steps to protect mental health care users from 'exploitation, abuse and any degrading treatment'. While section 11(1)(c) includes the broad prohibition on the use of mental health care, treatment and rehabilitation services 'as punishment or for the convenience of other people', the provision does not express additional protection to women with psychosocial disabilities.

As stated in section 1, the Act, as the primary mental health care legislation, serves as a guide for the development of policy, as well as the interpretation and implementation thereof. It can be argued that the absence of a gender dimension in the text of the Act has translated into weak protections for women with psychosocial disabilities in the recently adopted National Mental Health Policy Framework and Strategic Plan 2023-2030 (NMHPF), in which the few references to gender are vague or underdeveloped. For example, under 'Protection against vulnerability', the NMHPF briefly notes that targeted interventions are called for in the context of 'vulnerabilities associated with gender (including pregnancy)'.[92]

While a gender-sensitive or gender-responsive approach is thus absent from the text of the Act itself, the Act may still be interpreted by courts and quasi-judicial bodies in a manner that extends specific protections to women with psychosocial disabilities. Whether this has been the case to date is evaluated in this contribution with reference to two matters: the arbitration proceedings that took place following the Gauteng Mental Health Marathon Project (Marathon Project) and a recent Constitutional Court judgment, *Makana Peoples Centre v Minister of*

92 Department of Health *National Mental Health Policy Framework and Strategic Plan* (2023-2030) 32.

Health (*Makana*),[93] that considered whether select provisions of the Act passed constitutional muster.

5.3 The Gauteng Mental Health Marathon Project Arbitration Proceedings

The most infamous mental health care initiative in the post-apartheid era, the Marathon Project, took place over a decade after the adoption of the Mental Health Care Act. In 2015, the provincial Department of Health in Gauteng chose to terminate its agreement with the Life Esidimeni facility, where over 1 400 persons with psychosocial and intellectual disabilities were receiving mental health care. The responsible officials have since attempted to justify the termination of the agreement on a number of grounds, including by alleging that it was a deinstitutionalisation effort and an attempt to save costs – which was found to be false during the investigations of the Office of the Health Ombud and the subsequent arbitration proceedings.[94] What cannot be disputed is that the termination of the agreement resulted in the haphazard and hurried transfer of mental health care users from Life Esidimeni to so-called community-care organisations, most of which were underfunded, not validly licensed, and ill-equipped to provide mental health care services.[95] As a consequence of the traumatic transfer and horrific conditions of 'care' at the new facilities, an estimated 144 mental health care patients died.[96]

In the arbitration proceedings, presided over by former Deputy Chief Justice Dikgang Moseneke, the status of mental health care users as 'utterly vulnerable' was emphasised.[97] One of the first casualties was Deborah Phetla, who died while in solitary confinement at Takalani Home, a so-called community-care NGO; she was found with plastic and brown paper in her stomach, likely because the carers did not provide her with food or water.[98] While the arbitrator presented a number of

93 2023 (8) BCLR 963 (CC).
94 *Marathon Project Arbitration* (n 81) para 27, 30; Office of the Health Ombud *The Report into the Circumstances Surrounding the Deaths of Mentally Ill Patients: Gauteng Province* (2018) 18.
95 Office of the Health Ombud (n 94) 36-39.
96 *Marathon Project Arbitration* (n 81) para 2.
97 *Marathon Project Arbitration* (n 81) para 1.
98 *Marathon Project Arbitration* (n 81) para 88.

specific case studies like that of Deborah Phetla, and the victims' names are listed,[99] no express mention is made of the unique vulnerability experienced by female mental health care users who were victims of the failed Marathon Project. Only in one instance is gender mentioned in the arbitration proceedings, where the arbitrator notes 'three key risk factors' that the Office of the Health Ombud had identified among the persons transferred from the Life Esidimeni facility: 'transfer to non-governmental organisations rather than transfer to hospital; advanced age; *and being female*'.[100] However, no further comment or analysis from a gender perspective follows this reference. Of note further is that the South African Human Rights Commission, following the events of the Marathon Project, conducted an inquiry into the status of mental health care in South Africa. Gender does not feature in their report, with the exception of a reference to article 3 of the Disability Convention, where the report notes that 'all rights that are enjoyed by men and boys with disabilities should be equally enjoyed by women and girls with disabilities'.[101]

5.4 The *Makana* judgment

The failed Marathon Project featured prominently in the submissions by the applicant in the *Makana* matter, which was decided on 9 June 2023, approximately five years after the Marathon Project arbitration was delivered. In the applicant's reference to the horrors of the failed Marathon Project, the applicant argued that the Project revealed the poor state of mental health care in South Africa, which would be improved through the implementation of further safeguards through automatic judicial review in the context of involuntary mental health treatment.[102] The Constitutional Court delivered judgment in the *Makana* matter on 9 June 2023 after having considered the constitutionality of select provisions of the Act relating to involuntary mental health treatment.[103] Amongst other issues, sections 33 and 34 of the Act were alleged to be

99 See, eg, *Marathon Project Arbitration* (n 81) paras 14, 18, 88-90, 98-101.
100 *Marathon Project Arbitration* (n 81) para 91.
101 South African Human Rights Commission *Report of the National Investigative Hearing into the Status of Mental Health Care in South Africa* (14 and 15 November 2017) 13.
102 *Makana* (n 93) para 44.
103 *Makana* (n 93) para 3.

unconstitutional on the basis that the provisions allowing for involuntary detention without automatic judicial review violated sections 10, 12 and 34 of the Constitution – respectively, the rights to human dignity, freedom and security of the person, and access to courts. However, the Court demarcated the boundaries of the question before the Court clearly from the outset:

> The case is thus not about whether involuntary inpatient treatment is ever justified, or about the criteria which the Act sets for this to occur, or even about the procedure in general which the Act lays down.[104]

The Court accordingly does not engage in depth with, for example, 'the paradigm shift which the [Disability Convention] has been said to herald'.[105] One paragraph is devoted to a brief overview of the African Disability Protocol[106] and a single line to the African Charter.[107] The Court finds no violation of the abovementioned rights and sets aside the High Court's declaration of constitutional invalidity. In reaching this conclusion, the Court makes no reference to or consideration of gender in the matter. There is no mention of CEDAW, the Maputo Protocol or the General Comments of the supervisory bodies discussed above. The only reference to the right to health care services in this matter is tacked on the end of the judgment when the Court considers whether there has been a violation of the right to dignity of mental health care users:

> Involuntary inpatient treatment of a user who meets the statutory criteria for such treatment is consistent with respecting the user's dignity. Indeed, to withhold treatment from such persons might impair their dignity, along with their right to health care service in terms of section 27(1)(a) of the Constitution.[108]

However, this brief mention of the right to health care services could, instead, have been an exploration by the Court of the international and regional norms relating to the right to health, non-discrimination, or the prohibition on harmful practices. A key concern is thus the failure to consider the impact that the impugned provisions may have on women with psychosocial disabilities. A fact the Court seems to have overlooked is that that seemingly 'neutral' law may be discriminatory in practice, as

104 *Makana* (n 93) para 4.
105 *Makana* (n 93) para 3.
106 *Makana* (n 93) para 106.
107 *Makana* (n 93) para 83.
108 *Makana* (n 93) para 194.

set out by the CESCR on more than one occasion.[109] The Court considers the impact of the provisions but does so without consideration of the specific experiences of women, as strongly recommended by the various supervisory bodies,[110] thereby subscribing to an essentialist approach of persons with psychosocial disabilities. The Court further considers the provisions only as they are conceived and not as implemented, contrary to the requirements set out in *Grootboom* for socio-economic rights adjudication, as the Court in *Makana* declares:

> This case is also not about how the Act is being implemented in practice. Constitutionally compliant legislation may be implemented badly and constitutionally deficient legislation may be implemented humanely.[111]

In this way, the possibility of harmful practices, as prohibited by article 5 of the Maputo Protocol and article 11 of the African Disability Protocol, are overlooked. Overall, the *Makana* judgment fails to add a gender-based dimension to the provisions of the Act or even *obiter* insights on gender in the realm of mental health care under the present constitutional and statutory framework.

6 Conclusion

The Maputo Protocol and various other international and regional human rights instruments are unequivocal in extending specific protections not only to women and to persons with disabilities, each as distinct groups facing compartmentalised challenges – rather, the unique circumstances at the intersection of gender and disability must be considered when developing a right to health-based response to mental health care. The norms and obligations highlighted in section 3 align closely with the intersectional and anti-essentialist considerations set out in section 2.

The final Constitution does, as interpreted in decisions such as the *Mahlangu* matter, make provision for an intersectional approach that is cognisant of multidimensional forms of disadvantage. Further, the Constitutional Court's socio-economic rights jurisprudence does compel the state to consider the vulnerability of rights claimants when

109 CRPD General Comment 3 (n 62) para 17(e); CESCR General Comment 16 (n 63) para 8; CESCR General Comment 14 (n 52) para 20.
110 CEDAW Committee General Recommendation 24 (n 1) para 12.
111 *Makana* (n 93) para 4.

developing and implementing programmes to realise socio-economic rights.

However, from the provisions emphasised above in section 5, there is not a clear gender dimension evident in the text of the Mental Health Care Act and, in the absence of further interpretative guidelines beyond those noted in section 5, the Act can likely not offer sufficient protections to women with psychosocial disabilities, suited to their particular needs and interests. Recent adjudication of disputes related to the subject matter of the Act – the Marathon Project Arbitration and the *Makana* judgment – reveal not even superficial engagement with issues of gender as intersecting with disability to create compounded vulnerability.

The constitutional framework, measured against the three questions posed in section 2, shows promise in at least allowing for an intersectional and anti-essentialist analysis. However, the adjudication of disputes related to mental health care does not hold up to scrutiny under the application of the three questions. This failure may be attributable, in part, to deficiencies in the Mental Health Care Act itself.

To improve the circumstances of women with psychosocial disabilities, changes are called for in the legislative provisions relating to, at minimum, the following three broad aspects: resource allocation, stigma, and access to remedies and redress. Gender must be mainstreamed in mental health care legislation, including by making express mention of the state's specific obligations in respect of women with psychosocial disabilities.

First, improved resource allocation is crucial to ensure that mental health care for women meets the standards set by the AAAQ framework. The African Commission held in *Purohit* that concrete steps must be taken with the aim of progressively realising the right to health, while the CESCR further declared that resource allocation must be targeted to address the needs of vulnerable groups. A key provision to include in legislation to ensure adequate and equitable allocation of resources, as noted by the CEDAW Committee and other institutions such as the Southern African Development Community (SADC),[112] is that progress

112 Southern African Development Community 'SADC Gender Policy', November 2021, https://www.sadc.int/sites/default/files/2021-11/SADC_GENDER_POLICY_-_ENGLISH.pdf 21.

pertaining to women with psychosocial disabilities specifically must be monitored and reported on by the state.

Second, stigma must be eradicated within communities as well as amongst health care practitioners. The SADC, for example, recommends strengthening support for gender-focused advocacy groups, while the World Health Organization (WHO)[113] recommends entrenching provisions that demand gender-sensitive training for healthcare workers, including on the impact that gender-based violence may have on women's mental health. Article 5 of the Maputo Protocol, prohibiting harmful practices, must be borne in mind, as well as the specific measures noted in article 11 of the African Disability Protocol in respect to harmful practices, namely, legal sanctions and educational and advocacy campaigns.

Third, legislation must not only entrench protections against neglect and abuse, but must make provision for remedies and redress specifically for women with psychosocial disabilities whose rights have been violated. In this respect, the WHO recommends that legislation 'outline the procedures for the submission, investigation and resolution of complaint mechanisms', and ensure that these avenues for redress are accessible and widely-publicised'.[114]

While there is arguably also a need for increased rigour in the application of intersectionality in constitutional adjudication in relation to mental health care, the capacity of courts or a quasi-judicial forum to effect change is severely hindered by deficiencies in the Mental Health Care Act itself. The objects and provisions of the Act are in urgent need of reform to eradicate the pervasive legacy of a historically oppressive approach to mental health care for women and to establish a system of mental health care which is responsive to the particular needs of women in South Africa.

113 World Health Organization *Mental Health, Human Rights and Legislation: Guidance and Practice* (2023) at 81.

114 WHO (n 113) at 103.

Table of abbreviations

AAAQ	Availability, accessibility, acceptability, and quality
CEDAW	Convention on the Elimination of all Forms of Discrimination Against Women
CESCR	Committee on Economic, Social and Cultural Rights
ICESCR	International Covenant on Economic, Social and Cultural Rights
NMHPF	National Mental Health Policy Framework and Strategic Plan 2023-2030
SADC	Southern African Development Community
WHO	World Health Organization

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