Section 15. Human Rights and Health Care

This is one of 24 sections that make up the proposal to form TRISI. The other sections can be found at:
http://www.ptgrr.com/contents/get-involved/trisi-content

Reference: Brian Rogers. Trauma & Resilience-Informed Solutions Institute of Southern Africa – Proposal of a Trauma-Activist; PTG-RR; Sep 2015/15

This proposal is a living discussion platform. The answers do not lie in one person’s mind. Its objective is to attract enabling-capital which includes intellectual contribution and financial support. Should you wish to participate, please visit the TRISI web page. Furthermore, it is not in any way intended to presume scientific validity. The style, or method, is argumentative and documentary. It lacks academic skills which include the traditional representation of sources. Full acknowledgement is given at the point of disclosure so that the reader can identify the source and seek its original in order to explore further.

Human Rights and Health Care

1. Children’s Rights
2. The SAHRC
3. The Right to Health
   ▪ Dual Loyalty et al
4. South African Healthcare Services
5. The Forgotten Truth - Trauma: The consequence of Gross Human Rights Violations

“In time, we shall be in a position to bestow on South Africa the greatest possible gift - a more human face.” Steven Biko


“Our Lord revealed to the bees:
“Build dwellings in the mountains and the trees, and also in the structures which men erect.
Then eat from every kind of fruit and travel the paths of your Lord, which have been made easy for you to follow.”
From inside them comes a drink of varying colors, containing healing for humanity.
There is certainly a sign in that for people who reflect.”
(Surat an-Nahl: 68-69)

HARUN YAHYA; THE MIRACLE OF THE HONEYBEE

When things are going well, taking no risks seems like a very smart strategy. When times are tough though, you’ll notice expediency, which is meant to create all those happy, smiley faces, is suddenly wearing a smirk.

John Hunt and Sam Nhlengethwa; the art of an idea – and how it can change your life; Zebra Press; 2009
This section briefly reflects on the Human Rights and Health Care Governance that should prevail in solutions thinking and decision making. It also contains a most moving human story, courtesy of Kayum Ahmed Chief Executive Officer SAHRC, that simply cannot be left out in any discourse on Health Care in South Africa, especially if one is to apply a Trauma and a Resilience Lens to our citizens.

Max du Preez; A Rumour of Spring; Chap. 1 Multiply wounded, multiply traumatised; 2013; Zebra Press
‘Think of the enormous dispossession of land and its ramifications, culminating in the 1913 Natives Land Act. Think of the devastating consequences to families and communities of the migrant labour system (that still continues – we’ll talk about Marikana later). Think of the trauma of forced removals; the humiliation of pass laws; the psychological damage inflicted by treating generations of black South Africans as humans of lesser worth and capability; Bantu education; the ‘Whites Only’ signs on public amenities; police brutality; the torture and killing of anti-apartheid activists; and the ceiling put on black development by job reservation.’

One question needs to be asked of the existing organisational structures in our Mental Health Care industry: At what point is ‘doing nothing’ a violation of Human Rights? There are legal obligations to upholding Human Rights – or not infringing them. There are also moral obligations to uphold Human Rights. When you have the intellectual capacity and organisational competence like PsySSA and SASOP a platform exists to go much further than policy statements that reflect opinion to your union members. By avoiding a public – and by public is meant all the citizens of our country – stance on Human Rights in Health Care (and solutions to accomplishing them) a question must be raised as to the fulfillment of moral obligations to uphold Human Rights. Elite conferences and private lobbying simply are not enough. The issue cannot be more pointedly made than as reflected in the last subsection of Section 15 – “The Forgotten Truth - Trauma: The consequence of Gross Human Rights Violations”. In his stirring response to the 2013 murder of a young lady, Anene, Prof Juan Nel, current President of PsySSA asks the same question in a different way.

“The world needs a global health guardian of values, a protector and defender of health, including the right to health.”
Dr Margaret Chan, Director General, WHO

Rowe and Moodley; Patients as consumers of health care in South Africa: the ethical and legal implications; BMC Medical Ethics 2013, 14:15 http://www.biomedcentral.com/1472-6939/14/15
‘Terms reflect the times and the predominant ideology in a particular society at the time of their use. After World War II during which gross violations of human rights were committed by the Nazis, the world entered the human rights era with the adoption of the Universal Declaration of Human Rights in 1948. The Declaration is consistent with the Western notion of liberal individualism. This culture of human rights gained huge ground in South Africa with the abolition of the apartheid regime and the drafting of the new Constitution of South Africa containing the Bill of Rights. The Constitution aims to protect freedom of choice and individual rights such as the rights to Equality, Human Dignity, Life, Freedom and security of the person, Privacy, and Access to Health Care. Respect for these rights is a vital part of ethical health care. The health disparities present in South Africa represent the legacy of colonialism and apartheid.’
Key facts

- The WHO Constitution enshrines the highest attainable standard of health as a fundamental right of every human being.
- The right to health includes access to timely, acceptable, and affordable health care of appropriate quality.
- Yet, about 150 million people globally suffer financial catastrophe annually, and 100 million are pushed below the poverty line as a result of health care expenditure.
- The right to health means that States must generate conditions in which everyone can be as healthy as possible. It does not mean the right to be healthy.
- Vulnerable and marginalized groups in societies tend to bear an undue proportion of health problems.

"The right to health"

Underlying determinants

- water, sanitation, food, nutrition, housing, healthy occupational and environmental conditions, education, information, etc.

Health-care

AAAQ

Availability, Accessibility, Acceptability, Quality

(General Comment No. 14 of the Committee on Economic, Social and Cultural Rights)

According to the General Comment, the right to health contains four elements:

1. **Availability**: A sufficient quantity of functioning public health and health care facilities, goods and services, as well as programmes.

2. **Accessibility**: Health facilities, goods and services accessible to everyone. Accessibility has four overlapping dimensions:
   
   1. non-discrimination
   2. physical accessibility
   3. economical accessibility (affordability)
   4. information accessibility.

3. **Acceptability**: All health facilities, goods and services must be respectful of medical ethics and culturally appropriate as well as sensitive to gender and life-cycle requirements.

4. **Quality**: Health facilities, goods and services must be scientifically and medically appropriate and of good quality. The right to health, like all human rights, imposes on States Parties three types of obligations.
   
   - **Respect**: This means simply not to interfere with the enjoyment of the right to health ("do no harm").
• **Protect:** This means ensuring that third parties (non-state actors) do not infringe upon the enjoyment of the right to health (e.g. by regulating non-state actors).

• **Fulfil:** This means taking positive steps to realize the right to health (e.g. by adopting appropriate legislation, policies or budgetary measures).’ *Summarised from* *The right to health; Fact sheet N°323*

Ashley Dawson; *Documenting the Trauma of Apartheid: Long Night’s Journey into Day and South Africa’s Truth and Reconciliation Commission*

‘On 21st March 2003, retired Anglican Archbishop Desmond Tutu officially ended the work of South Africa’s Truth and Reconciliation Commission (TRC) by handing over the body’s final report to President Thabo Mbeki. This date, the anniversary of the 1960 Sharpeville massacre, when South African police fired into a crowd of peaceful protesters, was a particularly resonant one for the TRC to conclude its seven-year-long investigation into human rights violations committed during the era of strict racial segregation known as apartheid. Established in a last-minute codicil to the interim constitution that was drafted as part of the multi-party negotiations preceding South Africa’s first democratic election in 1994, the TRC heard the testimony of more than 21,000 victims of apartheid-era violence and their relatives in a series of emotionally charged public hearings.

In addition to recording the harrowing words of these witnesses to atrocity, commissioners also examined amnesty applications from perpetrators of human rights violations, and sought, more broadly, to promote reconciliation between the races in the new, democratic South Africa. While other institutional innovations such as the final drafting of a new constitution may prove to have a more dramatic impact on South Africa’s future, the TRC’s hearings were among the most gripping public events of the post-apartheid era. After decades in which a racist regime systematically silenced and brutalized them, victims of violence and their relatives appeared before the TRC in order to express their grief and rage. As a result of this process, the stories of ordinary people brutalized by apartheid were officially recognized and recorded by the new state. The TRC has, as a result, been widely perceived as drafting the first inclusive public history for a democratic South Africa.’

**Children’s Rights**

*Sr Silke-Andrea Mallmann; Building Resilience in Children Affected by HIV/AIDS; CPS Catholic AIDS; Catholic AIDS Action, Namibia*

**United Nations Convention on the Rights of the Child.**

**Background to international children’s rights**

‘In 1989, the United Nations (UN) drew up a treaty called the Convention on the Rights of the Child. This is often referred to as a “Bill of Rights” for children. One hundred and ninety-one governments have signed the treaty. Once a government agrees to support a convention by signing it, it becomes the same as law in that country. In other words, those governments must make sure that the rights mentioned in the convention are upheld in their countries. The only African member of the UN which did not sign the treaty was Somalia as it had no recognised government. The convention defines children as people under the age of 18. It describes a new vision of children who now have legally binding rights. It says that children are neither the property of their parents nor are they helpless objects of charity. They have rights, just like other human beings: their rights are not an option or a favour.’

‘The document was drawn up over a 10-year period and was negotiated by governments, non-governmental organisations, human rights advocates, lawyers, health specialists, social workers, educators, child development experts and religious leaders from all over the world. Because it was so broadly based, it reflects the main legal systems of the world. It also recognises the importance of tradition and cultural values for the protection and harmonious development of the child.’
‘What it does is provide the framework for the protection and promotion of basic human right for all children, all the time. It covers the civil, economic, social and political rights of children.’

‘Types of children’s rights
The rights can be grouped into four categories:

- **Survival rights** which include adequate living standards and essential health care. The rights focus on the child’s rights to live, grow and enjoy good mental and physical health.
- **Developmental rights** which include the rights to education, play and cultural activities. (“A child’s life must not only be saved, it must be worth living.”)
- **Protection rights** which safeguard children against harm and address the needs of children in especially difficult circumstances – for example those children who are abused, neglected or exploited – as well as children with special needs, children without families and children with disabilities.
- **Participation rights** which relate to self-determination, such as the right of children to be heard on matters affecting their own lives, and the right to play an active role in society.’

‘Have these rights been upheld?
In 2002 the UN held a special international conference on children, the Special Session of the UN General Assembly on Children, at which the nations of the world committed themselves to a series of goals to improve the situation of children and young people. Opening the General Assembly, UN Secretary-General Kofi Annan said much work had been accomplished but much still remained to do. Unfortunately, adults had failed children deplorably, he said. “One in three of you has suffered from malnutrition before you turned five years old. One in four of you has not been immunised against any disease. Almost one in five of you is not attending school … We, the grown-ups, must reverse this list of failures.”

A plan of action was adopted, “A World Fit for Children”. Among its pledges were to protect children and their families from “the devastating impact” of HIV/AIDS.

‘There are four priorities for children in the coming decade:
- promoting healthy lives.
- providing quality education.
- protecting against abuse, exploitation and violence.
- combating HIV/AIDS.

Obligations of 191 countries
‘The 191 countries which signed the Convention on the Rights of the Child should have legislation in place which promotes its aims. Even if they don’t, they are bound to uphold the principles of the treaty.’

‘What are some of the principles which must be upheld?

- **Put children first.** The convention states: “In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration.” This is of particular importance in the case of children who have suffered the loss of one or more parents. It also means that institutions, services and facilities responsible for the care or protection of children have to conform with certain standards, particularly in the areas of safety and health. There must be enough staff and suitable staff. Supervision has to be competent.
- **Listen to children.** It is not unlikely that children affected by HIV/AIDS may have other bodies make decisions about their lives. Those involved must assure the child, who is capable of forming his or her own views, that he or she has the right to express those views freely in all matters affecting him or her. These views should be listened to, with due weight being given in accordance with the age and maturity of the child. It also means that children have to be given the opportunity to be heard in any judicial and administrative proceedings affecting him or her.
- **Protect and report children in need.** Even if children are in the care of an adult, they still need to be protected. They need to be protected from mental or physical violence, injury or abuse (including sexual abuse), neglect, maltreatment or exploitation. Each of us has the duty to act when we suspect that a child may be in need of care or protection. Your country should have ways of identifying and reporting children
who have been maltreated. These cases must be investigated, followed up and taken to court where appropriate.

- **Care for children without parents.** Children with one or more parent with HIV/AIDS face having to live without their natural parents, temporarily or permanently. These children should be entitled to special State protection and assistance. This could be in the form of foster families, adoption, suitable institutions or kafalah of Islamic law. When decisions are made about the child’s future, thought should be given to placing the child in the same ethnic, religious, cultural and linguistic background. Children have a right to enjoy their own culture, to practise their own religion and use their own language.

‘Right to education.

When children are affected by the trauma of having ill and dying parents, or if they have HIV/AIDS themselves, sometimes schooling can suffer. The State is obliged to take measures to encourage regular attendance at schools and the reduction of drop-out rates. Even if children can no longer afford school, the convention states that primary education should be compulsory and free to all.

- No child should be discriminated against. The stigma of HIV/AIDS means children with infected parents or who are infected themselves are frequently subject to discriminatory treatment.
- No child shall be economically exploited. Often children with sick parents or who are orphaned find themselves trying to earn a living. They have a right to protection from any work which is hazardous, interferes with their education or harms them in any way, whether physically, mentally, spiritually or socially. Children have a right to rest, leisure and play.

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**The SAHRC**

“Every individual shall be equal before the law. Every human being shall be entitled to respect for his life and the integrity of his person. Every individual shall have the right to the respect of the dignity inherent in a human being and to the recognition of his legal status”.

*African (Banjul) Charter on Human and Peoples’ Rights*  
The South African Human Rights Commission  

＊Rowe and Moodley; Patients as consumers of health care in South Africa: the ethical and legal implications; BMC Medical Ethics 2013, 14:15  
[http://www.biomedcentral.com/1472-6939/14/15](http://www.biomedcentral.com/1472-6939/14/15)

‘Although the country enjoyed a peaceful transition from the apartheid era to the current constitutional democracy, the vast inequalities that were entrenched due to the previous discriminatory, racially based legislation are part of the legacy that remains. According to the World Bank, the gap between rich and poor may actually be widening. Despite being classified as an upper middle income country, South Africa has the highest level of inequality in the world with a GINI coefficient of 0.70 - the poorest fifth of the population accounting for 2% of the country’s income and consumption, and the richest fifth for 72%.’

＊The South African Human Rights Commission  

‘The South African Human Rights Commission is the national institution established to support constitutional democracy. It is committed to promote respect for, observance of and protection of human rights for everyone without fear or favour.’
CONSTITUTIONAL MANDATE

The mandate of the Commission as contained in Section 184 of the Constitution of the Republic of South Africa, Act 108 of 1996 is as follows:

1. The South African Human Rights Commission must –
   a) promote respect for human rights and a culture of human rights;
   b) promote the protection, development and attainment of human rights; and
   c) monitor and assess the observance of human rights in the Republic.’

The Bill of Rights (Chapter 2 of our Constitution) is the cornerstone of democracy in South Africa.
‘….It enshrines the rights of all people living in South Africa and affirms the democratic values of human dignity, equality and freedom. The South African Human Rights Commission (the Commission) is one of the constitutional institutions (Chapter 9) charged with the responsibility to respect, protect, promote, monitor and fulfil the rights contained in the Bill of Rights. In striving to be the focal point for human rights practice in South Africa, the Commission discharges the above mandate, through powers conferred by the Constitution and the South African Human Rights Act 54 of 1994.’

‘Advancing the human right to equality is part of the SAHRC’s work in terms of our legislative mandate. But more than that, it places the SAHRC under a moral obligation to protect and promote the rights of particularly women, people with disabilities, migrants and those living on the periphery of our society.’

Advocate Mabedle Lawrence Mushwana; Chairperson

In a case dealt with by the South African Human Rights Commission involving a racist teacher at a primary school, two students aged 11 and 13 decided to speak out about what they had observed. When they first reported the matter to their father, he refused to believe them. “It’s true,” they insisted. The story was chilling. They told their father about a white teacher who walked around the classroom holding up a mirror to black students. The teacher would ask: “What do you see?” When the child replied, “I don’t know, sir,” the teacher responded by saying, “A baboon... you see a baboon!”

In our investigation of this case, 81% of the children we interviewed indicated that they had informed their parents about what was taking place. They told their parents about the old South African flag in the front of the classroom. They told their parents about the corporal punishment being used by their teacher. They told their parents that they were being called “kaffirs”. The parents did not act.

When the Human Rights Commission conducted interviews with the parents, many of them stated that their children were used to being called derogatory names, that it was a joke, and that they did not take the complaints from their children seriously. So what made one parent decide to listen to his children and lodge a complaint with the Commission? In a school where the overwhelming majority of teachers are white and the majority of students are black, it was the white parent of the white children who decided to take up the matter. Black parents of black students who were targeted by the racist teacher remained silent.

This case can be contrasted with the recent Supreme Court decision in Prinsloo handed down on 15 July 2014. In this matter, a black mother was dropping off her two daughters at the University of the Free State when they were referred to as “fucking kaffirs” by a white man. The court found in favour of the mother and her daughters,
confirming the Magistrate’s Court decision of *crimen iniuria* and assault, and the sentence of a R6,000 fine or 12 months imprisonment, suspended for five years.

It would be easy to write the story of the Supreme Court decision in *Prinsloo* as an example of the resilience of a black mother and her two daughters, or describe the case of the Wilgehof Primary School as a story about the courage of two young white students and their father. And indeed it is. But these are also stories about the disempowerment and the violation of the dignity of black people.

In the *Prinsloo* case, the court noted that when the black parent was asked how she felt after being referred to in racist language, “she responded that she felt naked, worthless, belittled and dirty, and that she felt like something had been taken away from her”. It is therefore understandable that the black parents of students at Wilgehof Primary School remained silent.

Kayum Ahmed  
Chief Executive Officer  
31 July 2014

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**The Right to Health**

“Human rights are interdependent, indivisible and interrelated. This means that violating the right to health may often impair the enjoyment of other human rights, such as the rights to education or work, and vice versa.”

*WHO; The Right to Health- Fact Sheet No.31*

As human beings, our health and the health of those we care about is a matter of daily concern. Regardless of our age, gender, socio-economic or ethnic background, we consider our health to be our most basic and essential asset. Ill health, on the other hand, can keep us from going to school or to work, from attending to our family responsibilities or from participating fully in the activities of our community. By the same token, we are willing to make many sacrifices if only that would guarantee us and our families a longer and healthier life. In short, when we talk about well-being, health is often what we have in mind.”

‘Key aspects of the right to health’

1. The right to health is an inclusive right.
2. The right to health contains freedoms.
3. The right to health contains entitlements. These entitlements include:
   - The right to a system of health protection providing equality of opportunity for everyone to enjoy the highest attainable level of health;
   - The right to prevention, treatment and control of diseases;
   - Access to essential medicines;
4. Health services, goods and facilities must be provided to all without any discrimination.
5. All services, goods and facilities must be available, accessible, acceptable and of good quality.
6. A country’s difficult financial situation does NOT absolve it from having to take action to realize the right to health.’  
*Summarised from WHO; The Right to Health- Fact Sheet No.31*

‘The right to health in international human rights law’

The right to the highest attainable standard of health is a human right recognized in international human rights law. The International Covenant on Economic, Social and Cultural Rights, widely considered as the central instrument of protection for the right to health, recognizes “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.” It is important to note that the Covenant gives both mental health, which has often been neglected, and physical health equal consideration.’

‘The right to health and health duties in selected national constitutions’
Constitution of South Africa (1996):
Chapter II, Section 27: Health care, food, water and social security:
(1) Everyone has the right to have access to
   a. health-care services, including reproductive health care;
   b. sufficient food and water;
(2) The State must take reasonable legislative and other measures, within its available resources, to achieve the progressive realization of each of these rights.
(3) No one may be refused emergency medical treatment.

‘How does the principle of non-discrimination apply to the right to health?’
Discrimination means any distinction, exclusion or restriction made on the basis of various grounds which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise of human rights and fundamental freedoms.’

‘Not surprisingly, traditionally discriminated and marginalized groups often bear a disproportionate share of health problems. For example, studies have shown that, in some societies, ethnic minority groups and indigenous peoples enjoy fewer health services, receive less health information and are less likely to have adequate housing and safe drinking water, and their children have a higher mortality rate and suffer more severe malnutrition than the general population.’

‘HOW DOES THE RIGHT TO HEALTH APPLY TO SPECIFIC GROUPS?’
Some groups or individuals, such as children, women, persons with disabilities or persons living with HIV/AIDS, face specific hurdles in relation to the right to health. These can result from biological or socio-economic factors, discrimination and stigma, or, generally, a combination of these. Considering health as a human right requires specific attention to different individuals and groups of individuals in society, in particular those living in vulnerable situations. Similarly, States should adopt positive measures to ensure that specific individuals and groups are not discriminated against. For instance, (they) should disaggregate their health laws and policies and tailor them to those most in need of assistance rather than passively allowing seemingly neutral laws and policies to benefit mainly the majority groups.

‘Governments and health professionals should treat all children and adolescents in a non-discriminatory manner. This means that they should pay particular attention to the needs and rights of specific groups, such as children belonging to minorities or indigenous communities, intersex children and, generally, young girls and adolescent girls, who in many contexts are prevented from accessing a wide range of services, including health care. More specifically, girls should have equal access to adequate nutrition, safe environments, and physical and mental health services. Appropriate measures should be taken to abolish harmful traditional practices that affect mostly girls’ health, such as female genital mutilation, early marriage, and preferential feeding and care of boys.’

‘The right to health of persons with disabilities cannot be achieved in isolation. It is closely linked to non-discrimination and other principles of individual autonomy, participation and social inclusion, respect for difference, accessibility, as well as equality of opportunity and respect for the evolving capacities of children.’

‘Persons with disabilities face various challenges to the enjoyment of their right to health. For example, persons with physical disabilities often have difficulties accessing health care, especially in rural areas, slums and suburban settings; persons with psychosocial disabilities may not have access to affordable treatment through the public health system; persons with disabilities face various challenges to the enjoyment of their right to health. For example, persons with physical disabilities often have difficulties accessing health care, especially in rural areas, slums and suburban settings; persons with psychosocial disabilities may not have access to affordable treatment through the public health system; women with disabilities may not receive gender-sensitive health services.’

‘Medical practitioners sometimes treat persons with disabilities as objects of treatment rather than rights-holders and do not always seek their free and informed consent when it comes to treatments. Such a situation is not only degrading, it is a violation of human rights under the Convention on the Rights of Persons with Disabilities and unethical conduct on the part of the medical professional.’
‘Persons with disabilities are also disproportionately susceptible to violence and abuse. They are victims of physical, sexual, psychological and emotional abuse, neglect, and financial exploitation, while women with disabilities are particularly exposed to forced sterilization and sexual violence.’

‘The newly adopted Convention on the Rights of Persons with Disabilities requires States to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by persons with disabilities, including their right to health, and to promote respect for their inherent dignity (art. 1). Article 25 further recognizes the “right to the enjoyment of the highest attainable standard of health without discrimination” for persons with disabilities and elaborates upon measures States should take to ensure this right.’

‘D. Migrants
Migration has become a major political, social and economic phenomenon, with significant human rights consequences. The International Organization for Migration estimates that, today, there are nearly 200 million international migrants worldwide.’

‘OBLIGATIONS ON STATES AND RESPONSIBILITIES OF OTHERS TOWARDS THE RIGHT TO HEALTH
States have the primary obligation to protect and promote human rights. Human rights obligations are defined and guaranteed by international customary law24 and international human rights treaties, creating binding obligations on the States that have ratified them to give effect to these rights.

‘Progressive realization
Through their ratification of human rights treaties, States parties are required to give effect to these rights within their jurisdictions. More specifically, article 2 (1) of the International Covenant on Economic, Social and Cultural Rights underlines that States have the obligation to progressively achieve the full realization of the rights under the Covenant. This is an implicit recognition that States have resource constraints and that it necessarily takes time to implement the treaty provisions. Consequently, some components of the rights protected under the Covenant, including the right to health, are deemed subject to progressive realization.

Not all aspects of the rights under the Covenant can or may be realized immediately, but at a minimum States must show that they are making every possible effort, within available resources, to better protect and promote all rights under the Covenant. Available resources refer to those existing within a State as well as those available from the international community through international cooperation and assistance, as outlined in article 2 (1).

‘The role of international assistance and cooperation is reflected in other instruments as well, such as the Charter of the United Nations, the Universal Declaration of Human Rights and the Convention on the Rights of the Child. It is not a substitute for domestic obligations, but it comes into play in particular if a State is unable to give effect to economic, social and cultural rights on its own, and requires assistance from other States to do so. International cooperation is particularly incumbent upon those States that are in a position to assist others in this regard. States should thus have an active programme of international assistance and cooperation and provide economic and technical assistance to enable other States to meet their obligations in relation to the right to health.’

‘Three types of obligations
State obligations fall into three categories, namely the obligations to respect, protect and fulfil.

The obligation to respect
The obligation to respect requires States to refrain from interfering directly or indirectly with the right to health.

The obligation to protect
The obligation to protect requires States to prevent third parties from interfering with the right to health.

The obligation to fulfil
The obligation to fulfil requires States to adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures to fully realize the right to health.’
‘National health systems

The Special Rapporteur on the right to the highest standard of health has stressed that from a right-to-health perspective, a national health system should have several components: it should include an adequate system for the collection of health data to monitor the realization of the right to health; the data must be disaggregated on certain grounds, such as sex, age and urban/rural; it should include a national capacity to produce a sufficient number of well-trained health workers who enjoy good terms and conditions of employment; a process for the preparation of right-to-health impact assessments before major health-related policies are finalized; arrangements for ensuring participation in the formulation of health policies; effective, transparent and accessible mechanisms of accountability.’

‘In addition, the Declaration of Alma-Ata highlighted the central function played by primary health care in a country’s health system (art. VI). Hence, it stressed that States must formulate national policies, strategies and plans of action to launch and sustain primary health care as part of a comprehensive national health system (art. VIII).’

Rowe and Moodley; Patients as consumers of health care in South Africa: the ethical and legal implications; BMC Medical Ethics 2013, 14:15 http://www.biomedcentral.com/1472-6939/14/15

‘Ill people are very vulnerable and therefore exploitable which means they need much more secure protection than the marketplace can provide, although the Consumer Protection Act attempts to create protection in this context. A degree of government intervention is still necessary to ensure equity and distributive justice. The South African government plans to create a more equitable health care system through the introduction of National Health Insurance’

‘Currently South Africa has a pluralistic, transitional health care system which reflects this inequality. The two-tiered health care system has separate public and private streams. The public sector, funded by general tax, is based on a district health system approach with its emphasis on primary health care. Although there are out-of-pocket payers who can self-fund primary health care in the private sector, but rely on the state for secondary and tertiary care, 68% of the population depend entirely on the public health sector. Only 16% of citizens can afford private medical scheme cover and are able to access private health care exclusively, yet this portion of the population accounts for up to 45% of the total national health expenditure. The private sector also enjoys a much more favourable health care provider to patient ratio. The introduction of National Health Insurance (NHI) may help to achieve greater equity.’

‘In Section 27(1)(a) of the South African Constitution, access to health care services, including reproductive health care, is listed as a right. Section 27(2) makes it clear that the state must take reasonable measures within its available resources to ensure that this right is progressively realised. In other words, it is not something that can be taken away from someone. It is viewed as a universal human need. The poor and uninsured may not be deprived of health care due to lack of money to buy it. Health care is essential in the creation of health. Health is necessary for the fulfilment of human potential and to facilitate human thriving. Health care is not only for the individual good, but also for the common good [23]. It helps the family and community to bear the burden of disease and illness.’

Dual Loyalty et al

Physicians for Human Rights and School of Public Health and Primary Health Care, University of Cape Town, Health Sciences Faculty; Dual Loyalty & Human Rights In Health Professional Practice; Proposed Guidelines & Institutional Mechanisms

‘This project grew out of a disturbing trend: Governments and other third parties often demand that health professionals put allegiance to their patients aside, in deference to the demands of these powerful actors — often in a manner that violates patients’ human rights. Although documentation of this ethical and human rights problem, referred to here as the problem of dual loyalty and human rights — has been most thorough in South Africa, it is unfortunately a worldwide phenomenon. However, it is little recognized and rarely discussed. Indeed, in the course of this project we were surprised to see how few materials for guiding professional practice and institutional structures exist, even in organizations where this problem is pervasive, such as the military.’

The problem of dual loyalty – simultaneous obligations, express or implied, to a patient and to a third party, often the state – continues to challenge health professionals. Health professional ethics have long stressed the need for
loyalty to people in their care. In the modern world, however, health professionals are increasingly asked to weigh their devotion to patients against service to the objectives of government or other third parties. Dual loyalty poses particular challenges for health professionals throughout the world when the subordination of the patient’s interests to state or other purposes risks violating the patient’s human rights.’

‘Since ancient times, many societies have held healthcare professionals to an ethic of undivided loyalty to the welfare of the patient. Current international codes of ethics generally mandate complete loyalty to patients. The World Medical Association (WMA) Declaration of Geneva, the modern equivalent of the Hippocratic Oath, asks physicians to pledge that “the health of my patient shall be my first consideration” and to provide medical services in “full technical and moral independence.” The WMA International Code of Medical Ethics states that “a physician shall owe his patients complete loyalty and all the resources of his science.” In practice, however, health professionals often have obligations to other parties besides their patients – such as family members, employers, insurance companies and governments – that may conflict with undivided devotion to the patient. This phenomenon is dual loyalty, which may be defined as clinical role conflict between professional duties to a patient and obligations, express or implied, real or perceived, to the interests of a third party such as an employer, an insurer or the state.’

The dual loyalty problem is usually understood in the context of a relationship with an individual patient. In many parts of the world, however, clinicians have responsibilities to communities of patients, for prevention, health education and clinical care. Dual loyalty conflicts can and do arise in these settings as well. In cases where dual loyalty exists, elevating state over individual interests may nevertheless serve social purposes often accepted as justifiable. Evaluations for adjudicative purposes are a common example. A medical evaluation of an individual’s condition that is relevant to resolution of a lawsuit or a claim for disability benefits requires the health professional to express opinions about individuals that may result in their exclusion from desired benefits or their being deprived of a desired outcome. Such an evaluation is generally accepted as a justifiable departure from complete loyalty to the individual because of the overriding need for objective medical evidence to resolve the claim in a fair and just manner.’

Such socially and legally accepted departures from undivided loyalty to the patient are not restricted to evaluations. For example, a health professional may be required to breach confidentiality in a relationship with a patient in order to protect third parties from harm or to notify a health authority of communicable diseases for health surveillance purposes. However, in all circumstances where departure from undivided loyalty takes place, what is critical to the moral acceptability of such departures is the fairness and transparency of the balancing of conflicting interests, and the way in which such balancing is, or is not, consistent with human rights.’

‘Dual loyalty becomes especially problematic when the health professional acts to support the interests of the state or other entity instead of those of the individual in a manner that violates the human rights of the individual. The most insidious human rights violations stemming from dual loyalty arise in health practice under a repressive government, where pervasive human rights abuses, combined with restrictions on freedom of expression, render it difficult both to resist state demands and to report abuses. In addition, closed institutions, such as jails, prisons, psychiatric facilities and the military, impose high demands for allegiance on health professionals even in the face of often-common human rights violations against individuals held there. But violations of human rights at the behest of the state by health professionals also take place in open societies, for example, in cases of institutionalized bias or discrimination against women, members of a particular ethnic or religious group, refugees and immigrants, or patients who are politically or socially stigmatized. Violations of people’s rights of access to health care may also arise from policies imposed by governments, or in health systems, including privately managed health systems, in which health professionals are called upon to withhold treatment from certain groups of people in discriminatory ways.’

Physicians for Human Rights and School of Public Health and Primary Health Care, University of Cape Town, Health Sciences Faculty; Dual
Loyalty & Human Rights In Health Professional Practice; Proposed Guidelines & Institutional Mechanisms;
http://www.webcitation.org/getfile?fileid=3c4f1346ad5e376c0740c8b833dd7fb25ae0b01f9

“Physicians for Human Rights

‘Since 1986, PHR members have worked to stop torture, disappearances, and political killings by governments and opposition groups and to investigate and expose violations, including: deaths, injuries, and trauma inflicted on civilians during conflicts; suffering and deprivation, including denial of access to health care, caused by ethnic and
racial discrimination; mental and physical anguish inflicted on women by abuse; exploitation of children in labor practices; loss of life or limbs from landmines and other indiscriminate weapons; harsh methods of incarceration in prisons and detention centers; and poor health stemming from vast inequalities in societies. PHR also works to protect health professionals who are victims of violations of human rights and to prevent medical complicity in torture and other abuses. As one of the original steering committee members of the International Campaign to Ban Landmines, PHR shared the 1997 Nobel Peace Prize. Along with three other organizations, at the request of the Truth and Reconciliation Commission of South Africa, PHR prepared a report, Human Rights and Health: The Legacy of Apartheid, a review of human rights and ethical violations committed by members of the South African health professions under apartheid.’

Brendon Barnes and Saths Cooper; Reflections; on South African psychology with Saths Cooper; South African Journal of Psychology; September 2014 vol. 44 no. 3 326-332
‘... we cannot make excuses for the abuse of psychology. We should work to avoid any abuse of psychology. But we are not seeing such abuse at a political level where decisions are taken that are influenced by psychology, where we are seeing it is at the public level. For example, a lot of psychologists who work for trial lawyers end up being hired guns. So, we’ve got the Modimole case where the psychologist went out of her way to attempt to exonerate the accused, trying to show diminished responsibility, and in the Oscar Pistorius trial, the psychologist apparently wiping the tears off Oscar’s face. That is not the job of a psychologist. I think that we have not grounded our professionals in an ethical basis of working in a manner that does not compromise (1) their own integrity as a professional and (2) the integrity of the profession. For example, people fight about why their diagnosis of an accused or of the patient is correct. I find that repugnant. I think we should have a panel and make that panel available to court and say “choose your expert.” You are an expert to the court. How can we do that if we constantly are employed by one or the other side? That is a battle that needs to be fought.’

South African Healthcare

‘The Inequality of healthcare remains an area of concern. The Department of Health (DoH) implemented a two pronged approach to overhaul the health system namely by having the health system focus on PHC and by improving the functionality and management of the health system.’

The Department of Health (DoH) http://www.health.gov.za/
‘Vision - A long and healthy life for all South Africans
Mission - To improve health status through the prevention of illnesses and the promotion of healthy lifestyles and to consistently improve the healthcare delivery system by focusing on access, equity, efficiency, quality and sustainability.’

‘Legislation and Policies
The National Health Act, 2003 (act 61 of 2003) provides a framework for a single health system from South Africa. It highlights the rights and the responsibilities of healthcare providers and users, and ensures broader community participation in healthcare delivery, from health facility up to national level. It establishes provincial health services and outlines the general function of provincial health departments. The Act provides for the right to:

- Emergency medical treatment
- Have full knowledge of one’s condition
- Exercise ones’ informed consent
- Participate in decisions regarding one’s health
- Be informed when one participate in research
- Confidentiality and access to health records
- Complain about poor service
- Be treated with respect (health workers)

‘Health Professions Council of South Africa’

The HPCSA has a mandate to protect the rights of patients and to guide the professions across South Africa. While healthcare costs are a constant concern to all parties, only by working together within the prescribed guidelines can it be ensured that all parties’ right and responsibilities are met.

Its mandate includes:
- Coordinating the activities of the professional boards
- Promoting and regulating inter-professional liaison
- Determining strategic policy
- Consulting and liaising with relevant authorities
- Controlling and exercising authority over the training and practices pursued in connection with the diagnosis
- Treatment of prevention of physical or mental defects, illnesses or deficiencies in humankind
- Promoting liaison in the field of training
- Communicating to the minister information that is of public importance

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Health Professions Council of South Africa

The Health Professions Council of South Africa (HPCSA) is a statutory body, established in terms of the Health Professions Act and is committed to protecting the public and guiding the professions.

Overview

The HPCSA, in conjunction with its 12 Professional Boards, is committed to promoting the health of the population, determining standards of professional education and training, and setting and maintaining excellent standards of ethical and professional practice.

In order to safeguard the public and indirectly the professions, registration in terms of the Act is a prerequisite for practising any of the health professions with which Council is concerned.

The Council guides and regulates the health professions in the country in aspects pertaining to registration, education and training, professional conduct and ethical behaviour, ensuring continuing professional development, and fostering compliance with healthcare standards. All individuals who practise any of the health care professions incorporated in the scope of the HPCSA are obliged by the Health Professions Act No. 56 of 1974 to register with the Council. Failure to do so constitutes a criminal offence.

‘Vision and Mission’

Vision - The HPCSA’s vision is to enhance the quality of health by developing strategic policy frameworks for effective co-ordination and guidance of our twelve Professional Boards in:
- Setting healthcare standards for training and discipline in the professionals registered with the HPCSA;
- Ensuring on-going professional competence; and
- Fostering compliance with those standards.

Mission - Quality healthcare standards for all.

For Professionals

The Council regulates the health professions in the country in aspects pertaining to registration, education and training, professional conduct and ethical behaviour, ensuring continuing professional development, and fostering compliance with healthcare standards.
The Public
The Council regulates the health professions in the country in aspects pertaining to registration, education and training, professional conduct and ethical behaviour, ensuring continuing professional development, and fostering compliance with healthcare standards.’


‘A ministerial task team has found the Health Professions Council of South Africa (HPCSA) to be “in a state of multi-system organisational dysfunction” which has resulted in the body’s failure to function effectively. The team has recommended that an interim executive management team be appointed.’

‘The task team, led by the head of the University of Cape Town’s medical school, Bongani Mayosi, was given 60 days for its investigation, but eventually took six months to complete its work. Only the executive summary of the team’s 90 page report was released at a press conference in Pretoria on Thursday. The task team has concluded that the HPCSA’s chief executive, COO and head of legal services are unfit for their jobs and recommended that “appropriate disciplinary and incapacity proceedings” against them be instituted along with possible suspensions from their jobs.

All three refused to cooperate with the investigation.

Registrar Buyiswa Mjamba-Matsheba, who also functions as the chief executive, was found to display a lack of leadership and substandard work and COO Tshepo Boikanyo has been implicated in “acts of unauthorised, irregular and/or fruitless and wasteful expenditure”. Phelelani Khumalo, who is the head of legal services, is accused of overseeing a “dysfunctional system of professional enquiries which has prejudiced practitioners and the public”.’

NATIONAL HEALTH ACT 61 OF 2003; as amended by: the National Health Amendment Act 12 of 2013

“ACT
‘To provide a framework for a structured uniform health system within the Republic, taking into account the obligations imposed by the Constitution and other laws on the national, provincial and local governments with regard to health services; and to provide for matters connected therewith.

PREAMBLE RECOGNISING-
* The socio-economic injustices, imbalances and inequities of health services of the past;
* The need to heal the divisions of the past and to establish a society based on democratic values, social justice and fundamental human rights;
* The need to improve the quality of life of all citizens and to free the potential of each person;

BEARING IN MIND THAT –
* The State must, in compliance with section 7(2) of the Constitution, respect, protect, promote and fulfil the rights enshrined in the Bill of Rights, which is a cornerstone of democracy in South Africa;
* In terms of section 27(2) of the Constitution the State must take reasonable legislative and other measures within its available resources to achieve the progressive realisation of the right of the people of South Africa to have access to health care services, including reproductive health care;
* Section 27(3) of the Constitution provides that no one may be refused emergency medical treatment;
* In terms of section 28(1)(c) of the Constitution every child has the right to basic health care services;
* In terms of section 24(a) of the Constitution everyone has the right to an environment that is not harmful to their health or well-being;

AND IN ORDER TO –
Unite the various elements of the national health system in a common goal to actively promote and improve the national health system in South Africa;
* provide for a system of co-operative governance and management of health services, within national guidelines, norms and standards, in which each province, municipality and health district must address questions of health policy and delivery of quality health care services;
* establish a health system based on decentralised management, principles of equity, efficiency, sound governance, internationally recognised standards of research and a spirit of enquiry and advocacy which encourages participation;
* promote a spirit of co-operation and shared responsibility among public and private health professionals and providers and other relevant sectors within the context of national, provincial and district health plans,...`

‘51. Establishment of academic health complexes
The Minister may, in consultation with the Minister of Education, Establish -

(a) academic health complexes, which may consist of one or more health establishments at all levels of the national health system, including peripheral facilities, and one or more educational institutions working together to educate and train health care personnel and to conduct research in health services; and
(b) any co-ordinating committees that may be necessary in order to perform such functions as may be prescribed. (Commencement date of s. 51: 1 March 2012)’

‘52. Regulations relating to human resources
The Minister may make regulations regarding human resources within the national health system in order to -

(a) Ensure that adequate resources are available for the education and training of health care personnel to meet the human resources requirements of the national health system;
(b) Ensure the education and training of health care personnel to meet the requirements of the national health system;
(c) Create new categories of health care personnel to be educated or trained;
(d) Identify shortages of key skills, expertise and competencies within the national health system and to prescribe strategies which are not in conflict with the Higher Education Act, 1997 (Act No. 101 of 1997), for the -
(i) recruitment of health care personnel from other countries; and
(ii) education and training of health care providers or health workers in the Republic, to make up the deficit in respect of scarce skills, expertise and competencies;
(e) Prescribe strategies for the recruitment and retention of health care personnel within the national health system;
(f) Ensure the existence of adequate human resources planning, development and management structures at national, provincial and district levels of the national health system;
(g) Ensure the availability of institutional capacity at national, provincial and district levels of the national health system to plan for, develop and manage human resources;
(h) ensure the definition and clarification of the roles and functions of the national department, provincial departments and municipalities with regard to the planning, production and management of human resources; and
(i) Prescribe circumstances under which health care personnel may be recruited from other countries to provide health services in the Republic.’

‘91. Minister may appoint committees
(1) The Minister may, after consultation with the National Health Council, establish such number of advisory and technical committees as may be necessary to achieve the objects of this Act.’

‘South Africa has a population of 51.8 million people of which 7.5% over the age of five has a disability according to the latest census data (Statistics South Africa 2014). This statistic on the national prevalence of disability should be interpreted with caution since psychosocial and neurological disabilities are not accounted for (Statistics South Africa 2014). The most recent data on disability in South Africa is from the national census of 2011, which defined ‘disability’ as:
... a physical or mental handicap which has lasted for six months or more, or is expected to last at least six months, which prevents the person from carrying out daily activities independently, or from participating fully in educational, economic or social activities. (Statistics South Africa 2014)’
‘Equitable access to health care is a right of every person with a disability (United Nations [UN] 2008; Heapa, Lorenzo & Thomas 2009). A number of barriers to access in rural areas such as long distances to hospitals or clinics and poor public transport have been identified in the literature (Beatty et al. 2003; Harris et al. 2011; Maart et al. 2007). In South Africa the attitudes of society, and practices and ideologies, have been highlighted as important environmental barriers in rural areas (Maart et al. 2007). Societal perceptions, practices and ideologies form the basis of cultural beliefs, a known but less-explored barrier to accessibility of medical services in rural areas (MacLachlan 2006).’

‘All therapists were aware of these factors and indicated that a community based rehabilitation (CBR) approach would be far more beneficial in meeting the needs of the community (WHO 2010). They did, however, note that staff shortages and lack of vehicles for therapists to do home and clinic visits were amongst the main barriers to implementing a more effective CBR programme. Currently no new community health workers are being employed or trained in order to implement CBR in this rural district. Only community caregivers were employed by the DOH, and they were not trained or allowed to do CBR. In one of the rural hospitals eight therapists (four permanent and four community service therapists) are employed to service approximately 100 000 people over a surface area of 3000 square kilometres (Kwa-Zulu Natal Department of Health [KZN DOH] 2001b). This amounts to a therapist to patient ratio of 1 to 12 500,’

The Forgotten Truth - Trauma: The consequence of Gross Human Rights Violations

‘I would stop talking about the past, if it weren’t so present.’
~ Central African Republic politician Barthélemy Boganda, 1910–1959
Max du Preez; A Rumour of Spring; Chap. 1 Multiply wounded, multiply traumatised; 2013; Zebra Press

"Although psychiatry is expected to be a medical discipline which deals with the human being as a whole, in no other medical field in South Africa is the contempt of the person cultivated by racism, more concisely portrayed than in psychiatry." (WHO, 1981)

Max du Preez; A Rumour of Spring; Chap. 1 Multiply wounded, multiply traumatised; 2013; Zebra Press

‘A small number of people (about two thousand) were given the opportunity to deal with their pain and trauma when they appeared before the Truth and Reconciliation Commission (TRC). I was in charge of the television coverage of the TRC and met many of these people before and after they gave their testimony. Most of them felt huge relief, even closure, because they felt they were being heard and respected for the first time. I suspect many with similar experiences who did not appear before the TRC but who witnessed the process also felt some relief.

But the TRC dealt only with victims, relatives of victims or survivors of gross human rights violations (severe assault, torture, kidnapping and murder) between 1960 and 1994. Because of the nature and political environment of the TRC and its narrow focus, it could not deal with the broader psychological trauma of apartheid.’

‘The bottom line is that black, brown and Indian South Africans were deeply humiliated on a daily basis for many generations. One can put all the lipstick one wants on apartheid, but no one can ever deny the deep humiliation it brought.

We Afrikaners still talk about the injustices of the South African War of 1899–1902, about the inhumane concentration camps, the scorched-earth policies and the after-effects of the war. Some right-wing Afrikaners still prefer to call themselves ‘Boere’ instead of Afrikaners and still wave the flags of the old Boer republics.
That war ended more than a century ago. How can anyone expect black South Africans to forget and not talk about the injustices and humiliation that ended little more than twenty years ago?

‘Washington, D.C. — The following document was released by the American Association for the Advancement of Science:
A new report released today documents that white health professionals in South Africa ignored internationally recognized standards for medical personnel in support of apartheid policies and engaged in a pattern of abuses, including: refusing emergency care treatment; falsifying medical records; ignoring torture of detainees in prisons; denying or limiting access by blacks to ongoing medical care; and mistreating mentally ill and mentally retarded, including sterilizing patients without their consent. The report advocates a series of reforms, including an end to racial discrimination in the health care system, as the means to deal with the legacy of these abuses.’

Dr A Burke; Mental Health During Apartheid In South Africa: An Illustration Of How “Science” Can Be Abused
‘The effects of apartheid — poverty, malnutrition, infectious diseases and violence — have left a harsh legacy. The National Congress Health Care Plan of 1994 reported that Black South Africans comprise 95 percent of the 18 million people existing below the accepted "minimum living level" (US $216 per month per household) with 60 percent of this group living in total poverty. Illiteracy is a major problem with an estimated 3 million adults functionally illiterate. Violence caused more than 2,000 deaths per month in 1993. And a reported 150,000 people attempt suicide each year. This is the result of something less than slavery legitimized by psychiatry, a slavery that CCHR has continued to expose against enormous racial odds. It is not surprising that in April 1995, the new South African government announced a national inquiry into human rights abuses committed in psychiatric institutions throughout South Africa and also a review of the Mental Health Act.

‘The profession, however, remains shameless. During the apartheid years psychiatrists were quick to diagnose the response of Black South Africans to their oppression as a "persecution complex." Today, in the new South Africa, these enterprising professionals see only the opportunity to establish a new market. The long and painful recovery which black South Africans face has been given another psychiatric label: "post-traumatic stress disorder". Although South Africa is celebrating its 10 years of true democracy in 2004, we cannot merely close the chapter on Apartheid and merely move on. Surely we must ask ourselves what went wrong so that we can learn from history (or can we?).’

Brendon Barnes and Saths Cooper; Reflections on South African psychology with Saths Cooper; South African Journal of Psychology; September 2014 vol. 44 no. 3 326-332
‘In the Truth and Reconciliation Commission, there were devastating findings against the health professions. Psychology did not really present a picture of what it did to entrench apartheid. I was a member of the Board for Psychology, and I made the representations to the Reparations Committee. I remember saying that psychology has a long way to go but we are aware of these and we have to deal with these realistically. We cannot make excuses for our past, what happened in the past is there, but it is a route marker for what we should not do.’

Wahbie Long; RETHINKING "RELEVANCE":South African Psychology in Context; American Psychological Association; History of Psychology; 2013, Vol. 16, No. 1, 19–35
‘For several decades, psychology in South Africa has fielded awkward questions about its academic and professional “relevance.” Critics are framed nowadays in terms of the skewed racial demographics of the country’s psychologists and counselors, the inability of most practitioners to speak indigenous African languages, the discipline’s continuing Eurocentrism, and the perceived failure to respond appropriately to post-apartheid policy imperatives.

‘With the state apparatus () unraveling, critical psychologists slammed the discipline’s indifferent response to the human rights abuses of the day, accusing it of lacking “relevance.” They pointed out, variously, that the discipline was culturally insensitive (Holdstock, 1979, 1981a, 1981b), bourgeois (Turton, 1986), politically indifferent (Anonymous, 1986; Dawes, 1985; Liddell & Kvalsvig, 1990; Mauer, Marais, & Prinsloo, 1991; Stru’mper, 1981), economically inaccessible (Berger & Lazarus, 1987; Vogelman, 1987), and theoretically impoverished (Gilbert, 1989). It came as no surprise when, at its national conference in 1994, South African psychology admitted its silent complicity with apartheid rule (de la Rey & Ipser, 2004). Weighed down by a long and detailed involvement with racist ideology (S. Cooper, Nicholas, Seedat, & Statman, 1990; Duncan, van Niekerk, de la Rey, & Seedat, 2001;
Foster, 1991; Magwaza, 2001), the discipline was forced to confront its past in a manner that, for a hundred years, it had asked its patients to do.’

Prof Juan A. Nel, Anene, PsySSA Psychological Society of South Africa Issue 1 March 2013

‘It is said that South Africa has been caught up in a destructive pattern of violence, and in the process many have come to accept violence as inevitable, normal, ordinary and a legitimate solution to conflicts. Together with the collapse of apartheid and moves toward democracy, the use of violence for sovereign ends was delegitimised.’

‘PsySSA in its vision statement commits to the transformation and development of South African psychology to serve the needs and interests of all South Africa’s people. However, is South African Psychology really making itself and its potential contribution sufficiently visible in documenting and healing the physical, psychological and social wounds inflicted by the political violence of the past and the consequences of violence – for the individual, the family the community and society? Does organised psychology not only have the ‘political will’, but also the ability to make a meaningful difference? Is the voice of our profession audible enough? In respect of gender-based and sexual violence prevention, in particular, are we doing enough?

The unfortunate role of Psychology during the Apartheid era and the consequences for its credibility, integrity and future were under the spotlight during the South African Truth and Reconciliation Commission. It is my sincere wish that the contribution of psychology professionals and the discipline, itself, will in future not again be weighed only to be found not to measure up to the immense challenges our society is currently facing.’


‘1. The apartheid system was maintained through repressive means, depriving the majority of South Africans of the most basic human rights, including civil, political, social and economic rights. Its legacy is a society in which vast numbers of people suffer from pervasive poverty and lack of opportunities. Moreover, those who were directly engaged in the armed conflict (whether on the side of the state or of the liberation movements) suffered particular kinds of consequences.

2. The consequences of repression and resistance include the physical toll taken by torture and other forms of severe ill treatment. The psychological effects are multiple and are amplified by the other stresses of living in a deprived society. Hence, lingering physical, psychological, economic and social effects are felt in all corners of South African society. The implications of this extend beyond the individual - to the family, the community and the nation.

3. When considering the consequences of gross human rights violations on people's lives, it is hard to differentiate between the consequences of overt physical and psychological abuses and the overall effects of apartheid itself. This makes it difficult to make causal links or to assume that violations are the result of a particular experience of hardship. In many instances, however, violations undoubtedly played the most significant role as, for example, when a breadwinner was killed or when the violation caused physical disabilities, affecting individual and family incomes.

4. It must also be remembered that human rights violations affect many more people than simply their direct victims. Family members, communities and societies themselves were all adversely affected. Moreover, the South African conflict had effects far beyond those who were activists or agents of the state; many victims who approached the Commission were simply going about their daily business when they were caught in the crossfire. Human rights violations can also trigger a cascade of psychological, physical and interpersonal problems for victims that, in their turn, influence the functioning of the surrounding social system.’

PSYCHOLOGICAL CONSEQUENCES OF GROSS VIOLATIONS OF HUMAN RIGHTS

‘10. South Africa’s history of repression and exploitation severely affected the mental well-being of the majority of its citizens. South Africans have had to deal with a psychological stress which has arisen as a result of deprivation and dire socio-economic conditions, coupled with the cumulative trauma arising from violent state repression and intra-community conflicts.

11. Trauma has both a medical and psychological meaning. Medically it refers to bodily injury, wounds or shock. In psychological terms, it refers to "a painful emotional experience or shock, often producing lasting psychic effect."
12. Exposure to extreme trauma can lead to a condition known as post-traumatic stress disorder.’

‘13. Perpetrators of human rights violations used numerous tactics of repression, with both physical and psychological consequences. These found their expression in the killing, abduction, severe ill treatment and torture of activists, families and communities. Psychological damage caused by detention was not merely a by-product of torture by state agents. It was deliberate and aimed at discouraging further active opposition to apartheid. Jacklyn Cock says:

Torture is not only considered as a means of obtaining information on clandestine networks at any price, but also a means of destroying every individual who is captured, as well as his or her sense of solidarity with an organisation or community.’

Psychological problems

‘20. Internationally, the best-documented psychological consequences of human rights violations relate to the effects of torture. Torture can lead to wide ranging psychological, behavioural and medical problems, including post-traumatic stress disorder whose symptoms include "re-experiencing of the traumatic event, persistent avoidance stimuli associated with the event and persistent symptoms of increased arousal not present before the traumatic event."

21. Post-traumatic stress disorder is not, however, the only consequence of torture and human rights violations. Other problems include depression, anxiety disorders and psychotic conditions. The effects are multidimensional and interconnected, leaving no part of the victim's life untouched. Exposure to trauma can lead to sleep disorders, sexual dysfunction, chronic irritability, physical illness and a disruption of interpersonal relations and occupational, family and social functioning.

22. In many statements made to the Commission, deponents described symptoms of psychological disturbance. Although many deponents and victims referred to their symptoms, it was not possible to diagnose actual disorders or problems based on the statements and testimony at hearings.’

‘38. Psychological re-experiencing of the event can have debilitating consequences for survivors trying to rebuild their lives.’

‘Treatment in the South African context

47. In South Africa, the area of mental health has been historically neglected. There are few trained psychologists and clinical social workers, and few attempts have been made to provide culturally appropriate mental health care to all South Africans. At the time of reporting, mental health care still consisted largely of institutionalisation.

48. Moreover, dire social circumstances have made it difficult for individuals to deal with past psychological traumas. At times, current problems are merely symptoms of long-term traumatisation, compounded by impoverished living conditions. In South Africa, successful therapeutic interventions are difficult, because of the inability to protect the individual from further trauma.’

‘50. It is therefore difficult to distinguish between the response to the psychological effects of the violation and other stressful events in the life of the victim. Studies do, however, provide evidence that, in some individuals, exposure to violence has psychological effects independent of other associated factors causing stress.

51. It is also suspected that diagnoses of mental illness were also used to silence activists or opponents by condemning them to institutions where they were under the control of the state. Doctors and mental health professionals are alleged to have advised torturers on how to identify potential victims, break down their resistance and exploit their vulnerabilities.’

‘54. In order to heal, trauma victims must ultimately put words to their experience and thereby integrate the traumatic experience in order to find new meanings for themselves and their place in the world. An essential feature of recovery from trauma is re-establishing and normalising relationships of attachment with others.
55. Yet, while many victims of violations spoke of psychological problems that resulted from trauma, many others spoke of the strength and resilience they drew from friends and comrades in times of hardship. Courage, love and support networks kept many families and communities functioning and intact.

**Disruptions to Family Life**

‘74. As a core structure in society, the family should be protected and supported by the state. Apartheid generated a crisis in South African family life. Group areas legislation and forced removals have both been linked to disruptions in healthy family functioning, and the migrant labour system also deprived people of family life. Children were denied fatherly guidance and support during their formative years and the fact that women were obliged to take on domestic work meant that children were denied the care of their mothers. In trying to deal with these problems, extended family networks came into play.

75. The pressure on families was relentless. They experienced poverty and the degradation of living conditions in the townships, rural areas and informal settlements. Malnutrition was rife. Migrant labour policies meant that many fathers were away from their children for long periods and, perhaps more seriously in a patriarchal society, separated mothers from their children for long stretches. Even those parents who were able to live with their children worked long hours, sometimes leaving before the children went to school and coming home after they were in bed. In many cases, a traumatised child was simply an extra burden on the family; yet another problem for his or her already overburdened parents.

76. In South Africa, the roots of violence were partly political, but were also exacerbated by demographic and socio-economic circumstances. Socio-political factors, such as the structural, economic, cultural and racial inequalities imposed by the former state, led to and exacerbated violence: According to McKendrick and Hoffman (1990)

> The objective conditions of inequality make it clear that South Africa is a highly stratified society, characterised by intense structural and institutional injustice and violence.

77. Constant exposure to violence may lead to desensitisation, a situation where a person may deny his or her feelings. Responding to conflict with violence became a typical, rather than an isolated, phenomenon. Violence in South African society is also reflected in domestic violence such as wife and child abuse.’

‘79. The social pressures caused by apartheid and the repression associated with it have resulted in changes to the family structure in South Africa. Some families have been unable to withstand the pressure, whilst others have harnessed support and nurture from extended family networks to ensure their survival.’

**Family violence**

132. Domestic violence is associated with social strain and disintegration and often with a weakening or disruption of traditional norms governing interpersonal behaviour in families. Studies demonstrate that war experiences or prolonged detention may result in problems in marital relationships. This may be due to the direct effects of traumacoping behaviour, the inability of trauma survivors to function in expected family and social roles, and/or conflicts associated with changes in gender and family roles resulting from prolonged detention or migration. Family disintegration, such as the death of a parent or parent-in-law, also means the removal of those who would traditionally have mediated such conflict.

133. The effects of exposure to trauma have been linked to domestic violence in the home. At the Venda hearing, Mr Abel Tsakani Maboya alluded to domestic violence by an activist. His cousin, who was in the underground movement in Tanzania and had endured numerous detentions, committed suicide after a dispute with his wife.’

*Dr A Burke; Mental Health Care During Apartheid In South Africa: An Illustration Of How “Science” Can Be Abused*

‘In 1970, the Citizens Commission for Human Rights discovered the disused mining camps, and the horrific abuse that was occurring there. A report of this abuse was made to the World Health Organisation & the Red Cross. Instead of addressing the brutality and injustice, it gave in to psychiatric pressure and amended the Mental Health Act to make it a criminal offence to report on conditions in any psychiatric hospital or to photograph or sketch them. Then
it also banned *Peace and Freedom* issues exposing psychiatry’s abuses and stopped overseas journalists from entering South Africa if they reported on the psychiatric camps. It was a classic case of an attempt to kill the messenger. The South African Government’s response was to slap a total ban on all reporting of conditions in these hospitals, taking of photos or sketching of any part or person of or in these institutions (CCHR, 1995).

Medical professionals in the field of psychiatry were placed in the position of having to take positions of neutrality, in instances where they were not happy with the state of supply of medical treatment. If they were in agreement with the policies of the State, they did their work from a position of bias and racism, and aided the abuse that was taking place under the banner of science and acceptable practice. This moral disengagement hinged on the view that these persons were somehow ‘less human’ and perpetuated the practice of separation because of inequality and difference. If medical doctors spoke out against the abuse, they were persecuted, often not only by the police, but also by their peers. They were at risk of harassment, banning torture and murder. Because of this, most of the crimes of medical personnel – specifically in the case of psychiatrists – were of omission.’

*John R. Williams; Ethics and human rights in South African medicine; CMAJ 2000;162(8):1167-70*

‘The role of the South African medical profession in apartheid is now acknowledged as generally shameful. However, the profession has been one of the more active participants in the transformation of South African society during the past decade.’

‘In November 1997 the South African Truth and Reconciliation Commission released its 3500-page report on the human rights abuses perpetrated under apartheid. One chapter in this report deals with the health sector — the subject of Truth and Reconciliation Commission hearings in June of 1997. Numerous individuals and groups made presentations at these hearings; these were supplemented by written submissions, including a detailed survey of apartheid health care by the Health and Human Rights Project, a joint initiative of the Trauma Centre for Survivors of Violence and the Department of Community Health, University of Cape Town.’

‘The failings of the medical profession that were revealed at the Truth and Reconciliation Commission’s hearings were of 2 kinds: toleration or active promotion of inequities in health care and complicity in gross violations of human rights. The basis of inequity was a racially segregated health care system in which the facilities and services for nonwhites were vastly inferior to those for whites.’

‘The medical profession’s acquiescence in these inequities was acknowledged in the submission of the Medical Association of South Africa (MASA) to the Truth and Reconciliation Commission. From its establishment in 1927 until 1981 “MASA was relatively silent on human rights initiatives and was part of the apartheid system....The period [1982–1988] started with justification and defence of apartheid medicine.” The commission’s report condemns MASA for failing to draw attention to: “(a) the effects of the socioeconomic consequences of apartheid on the health of black South Africans, (b) the fact that segregated health care facilities were detrimental to the provision of health, (c) the negative impact on the health of millions of South Africans of unequal budgetary allocations for the health care of different ‘racial’ groups, (d) the fact that solitary confinement is a form of torture and (e) the severe impact of detention on the health of children.” The report is equally critical of similar failings on the part of the South African Medical and Dental Council, the body responsible for licensing, ethics and standards of practice.’

‘Despite many complaints, the South African Medical and Dental Council habitually failed to discipline or even investigate physicians involved in state-sanctioned violations of human rights. MASA was equally reluctant to criticize the police and their political masters. In 1980 the Executive Committee of MASA expressed full support of the South African Medical and Dental Council’s exoneration of Biko’s physicians. However, pressure from some of its members and from medical organizations outside the country forced MASA to reconsider the Biko case and eventually admit that the medical care of prisoners needed to be improved. Still, MASA was extremely reluctant to criticize the authorities for their mistreatment of physicians who opposed apartheid, such as Dr. Neil Aggett who died in suspicious circumstances while in police custody. Right up to the end of apartheid in 1990, white-dominated medical organizations such as the South African Medical and Dental Council and MASA were complicit in human rights abuses by their failure to criticize those responsible or even acknowledge that such abuses were widespread. The medical profession’s complicity in apartheid cannot be explained by ignorance of the human rights abuses that were being perpetrated. Numerous writers, including the physicians Trefor Jenkins and Max Price, published critiques of apartheid medicine, and few physicians could have ignored the publicity given to the negligent medical
treatment of Steve Biko. It is harder to determine whether physicians realized that apartheid medicine was contrary to the basic principles of medical ethics, however.’

‘Although individual physicians may not be to blame for ignorance of the basic principles of medical ethics, the same cannot be said for the medical profession as a whole. Except for the years 1976–1981, MASA was a member in good standing of the World Medical Association and presumably subscribed to their core ethical statements. These include the 1948 Declaration of Geneva, which states, “I will not permit considerations of religion, nationality, race, party politics or social standing to intervene between my duty and my patients,” the 1975 Declaration of Tokyo, which forbids physician participation in torture and other cruel, inhuman or degrading treatment or punishment in relation to detention and imprisonment, and the 1981 Resolution on Physician Participation in Capital Punishment, which states that “it is unethical for physicians to participate in capital punishment....” MASA, the South African Medical and Dental Council, the medical schools and the military and prison medical authorities failed to adequately promote these ethical principles, either within the medical profession or in public.’

‘The Truth and Reconciliation Commission report suggested numerous other initiatives for medical and health organizations to help overcome the legacy of apartheid in the health care professions and the health care system. Given the enormity of these tasks and the scarcity of resources to carry them out, it may take many years before respect for human rights is an integral part of health care in South Africa. Moreover, there is still a great deal of suspicion in South Africa about the sincerity of the medical profession’s new commitment to an ethos of human rights and ethics. Critics note that “[m]any of the individuals implicated in complicity with human rights abuses are still working in the health sector; many even hold senior positions in professional organizations and in the public health services. Their failure to ‘come clean’ regarding their past activities may present the most serious obstacle to reconciliation within the profession and to the success of institutional reform directed at building a human rights culture.’

Kelly Cogswell; Property of the State: The Torture of Queer Soldiers in the Apartheid Military http://www.thegully.com/essays/africa/000825aversion.html

‘South Africa’s military (and civil) law labeled male homosexuals criminals and threatened them with capital punishment. Add to this the army’s complete control over its conscripts, the South African Dutch Reformed Church and Gereformeerde Kerk’s view that homosexuals were sinners, the medical profession pathologizing of them as diseased, the white Christian National Party’s perception of itself as attacked from without, which heightened their already vicious intolerance of dissent or difference within, and you’ve got a lot of Mengeles on your hands.

Given all this, the official practice of reporting suspected homosexuals to both the military’s South African Medical Services (SAMS), and also to chaplains, was simply a preliminary to torture.

When forced to choose between the public shame of being handed over to the South African Police and prosecuted in a criminal court, or being treated in a psychiatric hospital, thousands of conscripts 'consented' to be treated by SAMS, especially if they themselves had internalized homophobia.

Some may have chosen differently if they’d known career military doctors in SAMS would be implicated in the torture of captives, including the use of electric shock treatments, and drugs banned by international treaties. Some SAMS medical doctors, along with military psychologists and psychiatrists, even took the initiative in developing new torture techniques.’

Mikki van Zyl; Jeanelle de Gruchy; Sheila Lapinsky; Simon Lewin; Graeme Reid; THE AVERTION PROJECT; Human rights abuses of gays and lesbians in the South African Defence Force by health workers during the apartheid era

The conversion therapy given to recruits in the armed forces did not change their sexuality, but often caused lasting physical and psychological damage. Informants suffered from headaches, depression and damage to their self-image as well as creating complications in their sexual relations. Many needed more therapy to try and heal the damage. Many whom we did not know about may have committed suicide as a result of these treatments. There is scant hope of redress for the human rights abuses they suffered.’

‘Aversion therapy falls into different categories: chemical, such as injections or drugs, electric shocks and noxious sensitisation. (Marks 1982:342) The method preferred by the doctor at 1 Military Hospital was a form of electric
aversion therapy, which is an attempt to change a patient’s behaviour patterns by associating negative experiences, such as the pain from an electric shock, with those behaviours one wanted to discourage.

Electrodes were strapped to the arms of the subject, and wires leading from these were in turn connected to a machine operated by a dial calibrated from one to ten. The subject was then shown black and white pictures of a naked man and encouraged to fantasise. The increase in the current would cause the muscles of the forearm to contract—an intensely painful sensation. When the subject was either screaming with pain or verbally requested that the dial be turned off, the current would be stopped and a colour Playboy centrefold substituted for the previous pictures .... [The doctor] would then verbally describe the woman portrayed in glowing and positive terms. This process would be repeated three times in a single session. Sessions were held twice daily for three to four days. People subjected to this therapy experienced long periods of disorientation afterwards.’

‘Not only did aversion therapy not change the sexual orientation of the subjects, but it left them with a profound sense of self-loathing and depression.’


‘South Africa’s apartheid army forced white lesbian and gay soldiers to undergo ’sex-change’ operations in the 1970’s and the 1980’s, and submitted many to chemical castration, electric shock, and other unethical medical experiments. Although the exact number is not known, former apartheid army surgeons estimate that as many as 900 forced ’sexual reassignment' operations may have been performed between 1971 and 1989 at military hospitals, as part of a top-secret program to root out homosexuality from the service.’

Mikki van Zyl; Jeannelle de Gruchy; Sheila Lapinsky; Simon Lewin; Graeme Reid; THE AVERSION PROJECT; Human rights abuses of gays and lesbians in the South African Defence Force by health workers during the apartheid era

‘We attribute the occurrence of human rights abuses against homosexuals to the institutional context of the SADF, and the structural location of the SAMS, where many health workers showed loyalty first to the Department of Defence and apartheid ideology, and not to their professional ethics and the care of their patients. We show how the effects of these human rights abuses affected the patients physically and psychologically. Many needed psychological counselling or therapy to restore their self-esteem.

The equality clause in the Bill of Rights of the South African Constitution (1996) guarantees people freedom of sexual orientation. The report makes recommendations on how these enshrined rights can be promoted actively by the SANDF, and national and professional health bodies to ensure that the highest standards of human rights practices are observed by their members. We suggest that homosexuals should receive visible support from institutions in the securing of equal human rights for all.’

‘The South African Medical Services [SAMS] provided the medical capacity needed by the South African Defence Force [SADF]. This service was listed as one of the units in the Department of Defence alongside the army, navy, air force and special forces. (Phillips 1989:21) Health professionals in the SAMS were drawn from both the Permanent Force as well as through conscription, and included doctors, nurses, psychiatrists and psychologists. However, they fell under the line command of military ranking. Medical personnel could not disobey a ‘lawful’ command. This created a great potential for a contradiction between medical ethics and the military. (HHRP, TRC submission)’

‘Perhaps the single document that most accurately sums up the attitude in psychiatry at 1 Military Hospital at Voortrekkerhoogte from 1971 to 1985, is in Resister No.47:11–17. We quote from it in detail, as it confirms in virtually every respect what our informants told us—both victims and ‘perpetrators’.

‘In the late 1960s a new ward was created ... to cater for the need of conscripts and members of the Permanent Force with psychological problems ....
RESISTER has conducted a series of interviews with former national servicemen who were either medical personnel or ‘patients’ in the military psychiatric wards between 1971 and July 1985. It became clear that the practice of psychiatry in the SADF has been closely wedded to the preoccupation of the military authorities to eliminate patterns of behaviour which do not conform to SADF discipline and the apartheid war effort. Even conscripts who refused to be posted for active service or attempted to conscientiously object on grounds of their opposition to apartheid have been committed to these wards. Army psychologists have found their motivations incomprehensible and labelled them as potentially ‘disturbed’. Resister No.47:11

‘In these wards, some gay conscripts were given aversion therapy by electric shock. This description gives a clear indication of the degree to which the army medical personnel were allowed to abuse their power to diagnose and treat. Even though the SAMS was represented on the South African Medical and Dental Council [SAMDC], the Biko case illustrates how state security organs influenced the workings of the SAMDC. There were close links between, for example, the SAMDC, the SAMS and other state security organs. All of these institutions colluded with, and indeed helped to formulate in some instances, state policy and turned a blind eye to human rights abuses. Thus the complicity of health professionals in violations of human rights was not the isolated actions of a few ‘bad apples’, but rather the inevitable result of an environment in which human rights abuses could be condoned by the medical establishment. De Gruchy et al 1998:977’

‘People who were considered ‘trouble-makers’ were sent to the psychiatric unit. A conscript who had objected on a moral basis to conscription was sent to see a psychiatrist in the military hospital. ‘The first thing that happens to everyone there is that you’re put on Valium. There are about 15 to 20 people in the ward all the time—there’s a high turnover of patients ... None of them had psychological problems, most were just sensitive and intelligent. It seemed to me that it was just their sensitivity that got them into shit. Every Tuesday they have a panel and everyone has to go before it. You walk in and sit down and you are supposed to talk to them. I said I wasn’t prepared to talk under those circumstances. [T]he man [psychiatrist] in charge, said I should go. I afterwards learned that when I walked out he said, “I don’t care about that man, he’s a conscientious objector. I am a soldier before I am a psychiatrist”. I can’t fully explain my impression of Ward 22—there was a strange atmosphere. It was like probing into people for the wrong reasons. I was there for two weeks and at the end of it they said there was nothing wrong with me.’ Resister No.25:19

‘One would expect a psychiatrist worthy of being called a professional not to succumb to prejudice, but to do a thorough investigation. During March he was admitted to 3 Military Hospital suffering from some kind of psychological disturbance. His condition deteriorated, and he attempted to kill himself by slashing his wrists. On 25th March he became ‘uncontrollable’. Instead of attempting to treat him, the military medical authorities transferred him to the detention barracks at Tempe. There, according to a SADF spokesman, he hanged himself with the bandages which had been tied around the wounds on his arms. Resister No.14:16

‘There was a strange connection between homosexuality and the consumption of illegal drugs: both were illegal, and therefore culprits were vulnerable to coercion if caught. Both were sent for psychiatric treatment, and both treated with electric shock aversion therapy. The moral panics surrounding homosexuality and use of illegal drugs meant that young people would be reluctant to confide in their parents if they were ‘guilty’. The wide-scale use of drugs also meant that it was likely a gay person might land up in the psychiatric ward for drug ‘rehabilitation’, and in an interview with the psychiatrist ‘confess’ to being gay.’

‘The above accounts show that some health workers, often Permanent Force ranks, showed little ethical accountability to their patients /clients, but used their skills and position to execute apartheid military ideology. Many others put their heads down and questioned nothing. Some staff members suffered deep dilemmas caused by dual loyalties: they struggled to remain ethically accountable to their patients within a system geared to implement state ideology.’