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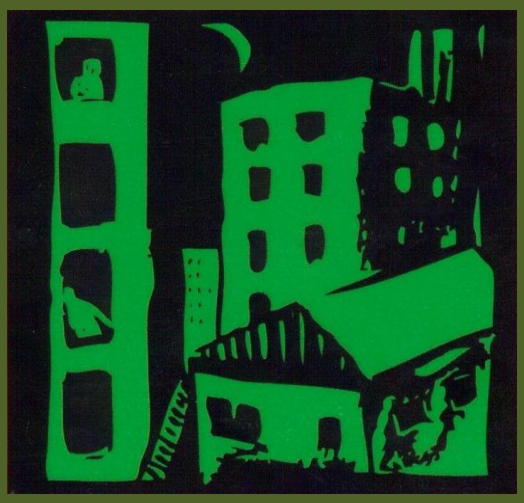

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Insufficient access to substance abuse treatment centres for illicit drug users and its potential effect on a foetus: a breach of the right to access health care services

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1 INTRODUCTION

This article will examine whether the State is in breach of section 27 of the Constitution[1], specifically the right to access health care services, in that it has failed to provide sufficient free of cost substance[2] abuse treatment centres and

* This article was inspired by a question posed to me by my husband, Dr Rabeen Lutchman, a paediatrician practicing in the Western Cape. He tried to determine the answer to the following question: who can be held responsible for the harm suffered by a child in *utero* for maternal illicit drug abuse? The paper is thus written with this question in mind.

[1] Constitution of the Republic of South Africa 1996.

[2] The term "substance" refers to drugs and alcohol use and is given this definition in s 1 of the Prevention and Treatment of Substance Abuse Act 70 of 2008 (PTSA).

facilities in South Africa for abusers of illicit drugs. It will be argued that as a result of this breach, the State has inadvertently aggravated another social ill, illicit drug abuse during pregnancy and consequent harm to the foetus. The article is divided into four parts. First, the legal problem will be examined in detail in order to understand the extent and severity of illicit drug use in South Africa as well as one important and under-researched consequence, the antenatal use of illicit drugs and consequent harm to the foetus. Secondly, legislative as well as other methods employed by the state to curb this issue are critically examined. The third part of the article advocates a legal framework to determine whether the State is in breach of its constitutional obligations in terms of section 27 of the Constitution. The international law counterpart to section 27, Article 12 of the International Covenant on Economic Social and Cultural Rights (1966) (ICESCR)[3], is examined in order to unpack the contents of the State's obligation. It is argued that the state has failed to provide sufficient free of cost substance abuse treatment centres and facilities and this is in breach of its constitutional obligations to respect, protect, promote and fulfil the right to access healthcare. As a result of this breach, the State may be found liable for not exercising due diligence in preventing, punishing and investigating the harm suffered by the foetus due to its mother's use of illicit drugs during pregnancy. Finally, the article concludes with recommendations as to how the State can improve the plight of illicit drug users, with a focus on pregnant users.

2 THE PROBLEM

2.1 General pattern of substance use

The Institute for Security Studies has reported that South Africa is listed by Interpol as one of the top four source countries for cannabis.[4] The United Nations Office on Drugs and Crime stated in its 2012 Report that South Africa was the regional hub for drug trafficking and the largest transit zone for illicit drugs in Southern Africa.[5]

A recent report from the South African Community Epidemiology Network on Drug Use (SACENDU) has found that the predominant substance of abuse in the country is alcohol.[6] The Western Cape, Limpopo and Mpumalanga are the only provinces where the predominant substances of abuse are cannabis and methamphetamine.[7] It is perhaps because of this phenomenon that Foetal Alcohol Syndrome is well documented and researched in the law but the corollary effect of illicit drug use is not. The SACENDU

[3] United Nations, The International Covenant on Economic, Social and Cultural Rights as adopted in 1966.

[4] Gastrow P "Mind-blowing: the cannabis trade in Southern Africa" Institute for Security Studies, (October 2003) http://www.issafrica.org/uploads/CANNABIS.PDF (accessed 31 March 2015).

[5] United Nations Office on Drugs and Crime "2012 World Drug Report" Regional Office for Southern Africa Newsletter (Issue 5 August 2012). Available at http://www.unodc.org/documents/southernafrica//Newsletter/UNODC_Southern_Africa_Newsletter_Issue_05_-_August_2012.pdf (accessed 31 March 2015).

[6] South African Community Epidemiology Network on Drug Use (2014) 7(1) SACENDU Research Brief at 1. Available at http://www.sahealthinfo.org/admodule/sacendu/sacenduBriefDec2013.pdf (accessed 29 August 2014).

[7] SACENDU report at 1.

is a network of researchers, practitioners and policy makers established in 1996 by the South African Medical and Research Council and the Department of Psychology at the then University of Durban-Westville (now known as the University of Kwazulu Natal) with funding from the World Health Organisation and the National Department of Health.[8] Its purpose is to document trends as well as the nature and pattern of alcohol and drug use at various treatments centres in all nine provinces over a six month period.[9] Three reports are generated over a 12 month period (January, June/July and December). For the purposes of this article, the most recent report (June – July 2013, Phase 35) has been examined.

The report refers to the use of alcohol and various drugs across the nine provinces over a six month period. Drug use is discussed by type: over the counter and prescription medicines; cannabis (dagga) and mandrax; cocaine; heroin; ecstasy, methamphetamine ("tik"), methcathinone (CAT) and LSD; and poly/other substance abuse.[10] All save the first category are illicit drugs, the use and possession of and dealing in which are prohibited by the Drugs and Drug Trafficking Act.[11] It is important to highlight that the abuse of illicit drugs is often done in tandem with alcohol abuse. This could perhaps make it difficult to analyse the use of one substance in isolation of the other. However, given the fact that the use of alcohol and over-the-counter and prescription drugs is not illegal, this article focuses on the prevalence and effect of illicit drugs. This investigation is necessary given that it is noteworthy to determine State duties to protect, promote and fulfil human rights, when the harm it seeks to prevent is illegal.

The SACENDU report finds that across all treatment centres in the nine provinces, the average age of patients was between 27-34 years.[12] A relatively higher proportion of female patients than male patients is documented to be users of methamphetamine, heroin and cocaine.[13] Male patients tend primarily to abuse alcohol.[14] Those patients addicted to illicit drugs tend to be younger than the alcoholic patients, and are usually unemployed.[15] In all provinces, except the Eastern Cape, cannabis is the predominant primary substance of abuse for patients under 20 years of age.[16] Methamphetamine is the primary substance of abuse for those under 20 in the Eastern Cape.[17]

From this useful data, a few salient points emerge. First, women are more at risk to be users of certain illicit drugs. Secondly, the data suggests that young women are

[8] For more information about SACENDU, see http://www.sahealthinfo.co.za/admodule/aboutsacendu.htm (accessed 29 August 2014).

[9] SACENDU report at 1.

[10] SACENDU report at 3.

[11] Act 140 of 1992 ("DDTA").

[12] SACENDU report at 3.

[13] SACENDU report at 2.

[14] SACENDU report at 3.

[15] SACENDU report at 3.

[16] SACENDU report at 3.

[17] SACENDU report at 3.

more prone to use certain illicit drugs. From these two points, one can conclude that child-bearing women are more at risk to abuse illicit drugs. Thirdly, those child-bearing women are more than likely to be unemployed and consequently would not be able to afford treatment at a private treatment centre. It seems as if these women would more than likely be dependent on State-funded treatment centres.

The importance of obtaining treatment at a treatment centre cannot be over-emphasised. A "treatment centre" is defined in the PTSA Act as a "centre established for the treatment and rehabilitation of service users who abuse or are dependent on substances".[18] "Treatment" is defined as "the provision of specialised social, psychological and medical services to service users and to persons affected by substance abuse with a view to addressing the social and health consequences associated therewith".[19] "Rehabilitation" is a "process by which a service user is enabled to reach and maintain his or her own optimal physical, psychological, intellectual, mental, psychiatric or social functional levels, and includes measures to restore functions or compensate for the loss or absence of a function".[20] Thus a treatment centre is, by its very definition, an important health care service, crucial to the recovery of a former substance abuser. One could go so far as to say that without sufficient access to this health care service, substance abuse cannot be eradicated in our society.

The effect of illicit drug use has widespread repercussions. One such repercussion is the consequence of illicit drug use during pregnancy and the harmful effect to the foetus.

2.2 Effect of illicit drug use on the growing foetus

The use of illicit drugs has damning consequences in poor socioeconomic communities as pregnant drug addicted women living away from cities are unlikely to seek antenatal care due to distances in location or shame and stigma.[21] If they remain unadvised, they will continue to use drugs during the course of their pregnancies. Maternal illicit drug use[22] is linked to adverse foetal brain development, premature birth, low birth weight and drug withdrawal symptoms.[23] These babies grow up and display neurobehavioral problems like mood dysfunction and impaired attention span.[24] It is also linked to long-lasting neurological deficits, such as, language and IQ deficits and the inability to

[18] Section 1 PTSA.

[19] Section 1 PTSA.

[20] Section 1 PTSA.

[21] Meyers B & Parry C "Access to substance abuse treatment services for black South Africans: findings from audits of specialist treatment facilities in Cape Town and Gauteng" (2005) 8 *South African Psychiatry Review* 15.

[22] Most recent medical studies conducted in South Africa have examined the use of methamphetamine use on pregnancy outcomes and the foetus, see further Madide A et al "Methamphetamine use by pregnant women: Impact on the neonate and challenges for the perinatal team" (2012) 22 *Obstetrics and Gynaecology Forum* 8; Meyers & Parry (2005) at 15.

[23] Madide et al (2012) at 9.

[24] Madide et al (2012) at 9.

habituate or self-regulate.[25] Congenital disorders and deformities have also been associated with drug use. It has also been thought that maternal drug use can lead to Sudden Infant Death Syndrome.[26]

There is some discrepancy as to the adverse effects of illicit drug use during pregnancy, with a recent study on the use in Cape Town suggesting that it has a "potentially adverse impact" on foetal brain development.[27] Another author holds the view that there is not enough data to demonstrate "a causal relationship between exposure to methamphetamine in *utero* and problems of infant development."[28]

These findings are controversial and some argue that the interpretation of the data does not look at the use of recreational drugs in isolation of other factors, such as, the mother's use of other drugs, cigarettes and alcohol, and other socioeconomic factors.[29] Others argue that scientists have been unable to reach consensus about the extent of the harm which drugs can inflict on a foetus in *utero*.[30] Scientists do seem to concur that the maternal use of illicit drugs can harm the new-born, despite the fact that the full nature and extent of it is not agreed upon.[31] A 2000 report states that infants exposed to cocaine in *utero* are on a par with their peers in size and health status by age two.[32] Fuelling this controversy is a 2001 report which states that cocaine has not been shown to cause any "major adverse developmental consequences in early childhood."[33] The report labels alcohol and tobacco as being more harmful to fetal development.

In the light of the above mentioned discussion and since medical knowledge today presents the general view that illicit drug usage does have (or potentially has) an adverse impact on the development of a foetus, it will be assumed for the purposes of this article that this is true. The extent and nature of the adverse impact will not be discussed further. At this point of the analysis, it is important to determine what the State is doing to address the scourge of illicit drug abuse in the country.

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[25] Fentiman L "Pursuing the perfect mother: Why America's criminalization of maternal substance abuse is not the answer – a comparative legal analysis" (2008-2009) 15 *Michigan Journal of Gender & Law* 389 at 396.

[26] Jones HE et al "Pregnant and Nonpregnant women in Cape Town, South Africa: Drug use, sexual behavior and the need for comprehensive services" (2011) *International Journal of Paediatrics* 1 at 6, Roberts D "Punishing Drug addicts who have babies: women of color, equality, and the right of privacy" (1991) 104 *Harvard Law Review* 1419 at 1429.

[27] Jones et al (2011) at 6.

[28] Fentiman (2008-2009) at 396 citing various sources in footnote 22.

[29]Roberts (1991) at 1429.

[30] Fentiman (2008 -2009) at 395.

[31] Fentiman (2008 – 2009) at 395, referring to Steinberg D & Gehsan S 'State responses to maternal drug and alcohol use: An Update' *National Conference of State Legislatures* (2000) 1 at 25 http://www.ncls.org/programs/health/forum/maternalabuse.htm (accessed on 5 December 2011).

[32]Fentiman (2008 – 2009) at 395, referring to Steinberg & Gehsan (2000) at 25.

[33] Fentiman (2008-2009) at 396 citing Chavkin W "Commentary: Cocaine and pregnancy – time to look at the evidence" (2001) 285 *Journal of American Medical Association* 1626 .

3 STATE MEASURES

In terms of the domestic drug laws, the Drugs and Drug Trafficking Act 140 of 1992 criminalises the use, possession and dealing of illicit drugs.[34] This in essence gives effect to South Africa's international law obligations in terms of the Convention on Psychotropic Substances (1971) (CPS)[35] and the Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances (1988) (CITNDPS).[36]

A look at the State's legislative obligations to rehabilitate substance abusers is necessary. The PTSA is centred on devising a comprehensive and national response for the combatting of substance abuse.[37] It is significant to this study because it details the State's response to the treatment of illicit drug users. In terms of section 3, the State is required to take reasonable measures within available resources to combat substance abuse. State interventions in this regard are threefold: reduction of demand, harm and supply of abusive substances. With respect to demand reduction, the State is required to provide services which discourage the abuse of substances by the public. Secondly, the State is tasked with providing holistic treatment for substance users and their families to mitigate the social, psychological and health impacts of substance use. Thirdly, the State must reduce the supply of illicit substances through law enforcement and criminalisation efforts, working in tandem with other laws, such as the DDTA. The Minister of Social Development, and indeed the Department of Social Development, are tasked with the function of facilitating integrated programmes for the prevention of substance abuse.[38] Such programmes are to be focused on, among other factors, the preservation of the family structure.[39] The legislation also creates the Central Drug Authority (CDA) which is tasked with monitoring the National Drug Master Plan (NDMP) (which has to be adopted by Cabinet).[40]

The NDMP is a policy document outlining the goals and vision of the state to reduce substance abuse.[41] The CDA, which monitors and implements the NDMP, is an inter-governmental body consisting of representatives from various government departments such as welfare, justice, police services, health, education, home affairs, trade and industry, revenue services, correctional services, labour, safety and security,

[34] See further Chapter II DDTA.

[35] South Africa acceded to the CPS in 1972. The status of treaty ratifications by country is documented at https://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=VI-16&chapter=6&lang=en (accessed 4 September 2014).

[36] South Africa acceded to the CITNDPS in 1998. The status of treaty ratifications by country is documented at https://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=VI-19&chapter=6&lang=en (accessed 31 March 2015).

[37] "Substance" means chemical, psychoactive substances that are prone to be abused, including tobacco, alcohol, over the counter drugs, prescription drugs and substances defined in the DDTA (per cap 1 of the PTSA)). This includes the recreational drugs under discussion in this article.

[38] Section 8 PTSA.

[39] Section 9(2)(a) PTSA.

[40] Section 2 PTSA.

[41] Per Department of Social Development – www.dsd.gov.za/cda/index.php (accessed 29 August 2014).

as well as the National Youth Commission and the Medicines Control Council.[42] According to the Department of Social Development "[T]he CDA will use the National Drug Master Plan to drive alcohol control legislation to promulgation in order to save lives and reduce the incidence of Foetal Alcohol Syndrome (FAS)."[43] The Department also lists the health risks associated with drug addiction are listed as poor nutrition and below average weight, low self-esteem, depression, physical abuse, preterm labour or early delivery, and other serious medical and infectious diseases.[44] The NDMP itself does not refer to the harm suffered by the foetus due to illicit drug abuse. These declarations and omissions seem to indicate that the State is not specifically focused on the harm suffered by the foetus due to illicit drug abuse during pregnancy.

Importantly, the nature of the treatment required by substance abusers is rehabilitation at a treatment centre.[45] A closer examination of the PTSA Act reveals that the state must establish, maintain and manage at least one public treatment centre in each province for the reception, treatment, rehabilitation and skills development of substance users.[46] In the Western Cape, for instance, this treatment centre is the De Novo Treatment Centre in Kraaifontein.[47] Currently, it has resources to treat up to 80 adults at a time. Due to the limited space, it can take six weeks to five months for an addict to gain admission to the treatment centre.[48] According to the Regulations to the Act, therefore no formal criteria for admission to a public treatment centre. The existence of one public treatment centre in each province has proven to be at times disastrous for those seeking help for their addiction. The long waiting period may become a time to revert to old behaviour and consequently decide not to obtain treatment altogether.[49]

Whilst the only financial obligation on the State is to establish at least one treatment centre in each province, it may also choose to fund service providers[50], community based services[51] and public halfway houses.[52] When this occurs, service providers may determine who should qualify for such services.[53] The criteria may

[42] Section 53(2) PTSA.

[43] Available at http://www.dsd.gov.za/cda/index.php (accessed on 29 August 2014).

[44] Available at www.dsd.gov.za/cda/index.php?option=com_content&task=view&id=104&Itemid=129 (accessed 4 September 2014).

[45] Section 1 PTSA.

[46] Section 17(1) PTSA.

[47] This information was retrieved from the Western Cape government website http://www.westerncape.gov.za/facility/de-novo-treatment-centre-state-owned (accessed 29 August 2014).

[48] Naidoo Y "Rehab out of reach for desperate addicts" *IOL* (27/01/2007). Available at http://www.iol.co.za/news/south-africa/rehab-out-of-reach-for-desperate-addicts-1.312670#.VAB_UvmSx1U (accessed 29 August 2014).

[49] Naidoo (2007).

[50] Section 7(1) PTSA.

[51] Section 12 PTSA.

[52] Section 20 PTSA.

[53] For instance, see the criteria to obtain treatment at the Ramot Treatment Centre for addiction. Available at http://www.ramot.co.za/images/CRITERIA_-_STATE_SUBSIDIZED_PASTIENTS_-August_2012.pdf (accessed 29 August 2014).

include the prognosis for effective treatment, the absence of criminal records and gang affiliation, and earning below a particular salary bracket.[54]While such a filter may assist the State in helping the most impoverished sector of society, it has the effect of limiting the number of approved applications. The criterion of the absence of a criminal record is theoretically problematic for illicit drug users since the use and possession of illicit drugs is a criminal offence in terms of the DDTA. Would this imply that only alcoholics need apply since the use of alcoholic substances is not a criminal offence? Furthermore, the addition of an income parameter has the effect of ignoring the pressing needs of the middle to lower income sectors of society. The predicament of addicts within this band becomes all the more dire when one considers the cost of treatment at a private treatment centre.[55] It has become known as "big business that feeds on itself" because the industry is typified by repeat customers.[56] According to the Mitchell's Plain Crisis Line Trauma Centre, about 55% of the addicts who have obtained their assistance have returned to drugs.[57] This is due to the nature of the recovery process[58] as well as the "drug-infestation" in certain communities.[59] A newly reformed addict who has received treatment at a public treatment centre has few options if he returns to drugs. It seems unlikely that such a person will gain access to a public treatment facility for a second time due to the poor first round prognosis.

What can be deduced is the following: those at the margins of society, due to either being engaged in criminal activity or due to living in poverty, and those living far away from the city centres, will most likely not gain access to the State funded facilities. Even if an addict does meet the criteria for State funded facilities at a private treatment centre, there is no guarantee that he or she will gain admission due to the highly competitive process. These facts all seem to point to ineffective State action. The State's formal legislative obligations are met, but it is not making a significant impact on those who need it the most.

[54] At the Ramot Treatment Centre for Addiction only a patient earning less than R7000 per month may apply for a state-funded bed at their facility. See http://www.ramot.co.za/images/CRITERIA_-_STATE_SUBSIDIZED_PASTIENTS_-August_2012.pdf (accessed 31 March 2015).

[55] For instance, the Cape Town based Stepping Stones Addiction Centre, charges R56 000 for locals and €6 700 for foreign clients, see Pampalone T "Cape Town's rehabs for the rich and infamous" *Mail & Guardian* (2014). Available at http://mg.co.za/article/2014-07-03-cape-towns-rehabs-for-the-rich-and-infamous (accessed 4 September 2014). The Ramot Treatment Centre for Addiction caters for a slightly lower salary bracket. Medical aid tariffs are charged and its general tariff for a five week programme is R19 800. For more information see http://www.ramot.co.za/admissions/tariffs (accessed 4 September 2014).

[56] Pampalone (2014).

[57] Naidoo (2007).

[58] Pampalone (2014).

[59] Naidoo (2007).

4 SECTION 27 ANALYSIS

4.1 The provision and its link to Article 12 of the ICESCR

Section 27(1)(a) of the Constitution states that everyone has the right to access healthcare services. The State must take reasonable legislative and other measures within its available resources to achieve the progressive realisation of this right.[60] The State is obliged to respect, protect, fulfil and promote all rights in the Bill of Rights. This has been interpreted by the Constitutional Court to mean that the fulfilment of the right is dependent upon the resources available for such purpose, which may have the effect of limiting the right itself. Hence the obligation on the State is a qualified one.[61]

The right to health is rooted in Article 12 of the ICESCR which guarantees everyone the right to the enjoyment of the highest attainable standard of mental and physical health. South Africa ratified the ICESCR[62] on 12 January 2015. The ICESCR will come into force after the passing of three months since the deposit of the instrument of ratification.[63] As a signatory, South Africa's obligations to the ICESCR were merely to ensure that it did not act against the objects and principles of the Covenant.[64] It was technically not legally bound by the provisions of the ICESCR. After ratification, the State is bound, subject to reservations made.[65] It has been argued that few changes will need to be made by South Africa, given that the Bill of Rights contained in the Constitution is modelled on the ICESCR and there are currently legislation and policies in place giving effect to socio-economic rights.[66] However, lacunae in the national law will have to be identified and addressed. The General Comments of the Committee on Economic Social and Cultural Rights may assist the State in this regard.

In General Comment No. 14 (2000), the Committee, as the interpretative authority on the ICESCR, stipulates the essential elements of the right to health.[67] The Committee is careful to point out that these four elements are interrelated: availability; accessibility; acceptability; and quality. In terms of availability, the State is to provide functioning public health and health-care facilities, goods, services and programmes in sufficient quantity. With regards to accessibility, the state is to ensure that access to these services are offered non-discriminately, must be physically and economically accessible and information about these services must be freely available. All health

[60] S 27(2) Constitution.
[61] *Soobramoney v Minister of Health, Kwazulu-Natal* 1998 (1) SA 765 (CC) at para 11.
[62] For more information on the status of ratifications, see http://tbinternet.ohchr.org/_layouts/TreatyBodyExternal/Treaty.aspx?Treaty=CESCR&Lang=en (accessed 4 September 2014).
[63] Art 27(2) ICESCR.
[64] Article 18, Vienna Convention on the Law of Treaties as adopted in 1969.
[65] Interestingly, the only reservation made by South Africa is with respect to the right of education – see http://indicators.ohchr.org/ (accessed 31 March 2015).
[66] Chenwi L & Hardowar R "Promoting socio-economic rights in South Africa through the ratification and implementation of the ICESCR and its Optional Protocol" (2010) 11 *Economic Social Rights Review* 3 at 6.
[67] Committee on Economic, Social and Cultural Rights "General Comment No. 14 (2000): The right to the highest attainable standard of health (article 12 of the International Covenant on Economic, Social and Cultural Rights)" E/C.12/2000/4.

facilities, goods and services must be respectful of medical ethics and (acceptable) cultural standards and be of good quality. The precise nature of the facilities, goods and services will depend on the State's development level. The right to health is to be progressively realised within the maximum of a State's available resources.[68] This requires the State to take concrete steps forward. A State's inability to comply is distinguished from a state's unwillingness to comply.

Since South Africa is bound by the provisions of the ICESCR, the Committee's interpretation of the right to health will have an impact on the interpretation of section 27(1)(a) of the Constitution. In applying this interpretation to the South African context, it becomes clear that with regards to drug rehabilitation, the current status quo is inadequate. For instance, the State is bound to provide treatment centres in sufficient quantity. The legislative obligation to provide at least one treatment centre in each province has proven to be insufficient and does not meet the pressing needs of the community. An applicant may have to wait months to receive treatment, which further excarbates the problem. It also does not take into consideration that treatment for drug addiction is a process which often involves subsequent treatment. Furthermore, the exclusionary practices of certain private treatment centres that provide State-funded treatment on a limited basis is a clear violation of the element relating to accessibility. Requiring applicants to declare their personal income, criminal record status and gang affiliation fails to acknowledge that those categories of individuals may be the most vulnerable to illicit drug use.

In terms of the Maastricht Guidelines on Violations of Economic, Social and Cultural Rights (Maastricht Guidelines), the obligations to respect, protect and fulfil include obligations of conduct and result.[69]The Maastricht principles are interpretative guidelines to the ICESCR. Obligations of conduct require reasonable action, calculated to realise the enjoyment of a particular right.[70] Obligations of result require the State to achieve certain targets to meet a particular standard.[71] In this situation, the State has not taken reasonable action to protect the right to health – its obligations are minimal with regards to providing drug rehabilitation treatment and can hardly be said to be reasonable action calculated to realise the enjoyment of a particular right. The State's failure to respect, protect, promote and fulfil the right to health, is a violation of section 27(1) of the Constitution. The question is: can this violation be justified in terms of the constitutional limitations clause?

Section 36 of the Constitution allows for rights in the Bill of Rights to be limited only if reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom. Factors that must be considered are the nature of the right, the importance and purpose of the limitation, the nature and extent of the limitation, the relation between the limitation and its purpose and less restrictive

[68] Art 2(1) ICESCR.

[69] "The Maastricht Guidelines on Violations of Economic, Social and Cultural Rights" (1998) 20 *Human Rights Quarterly* 691 at 694.

[70] Maastricht Guidelines at 694.

[71] Maastricht Guidelines at 694.

means to achieve the purpose. The law limiting this right could be said to be the PTSA. The right is to be progressively realised within the available resources of the State.[72] Interestingly, this provision is similar to, but not the same as, Article 2(1) of the ICESCR which provides that the rights (in the Covenant) are to be progressively realised within the maximum of the State's available resources. Hence it would appear that the international obligation is more onerous than the domestic obligation.

Does the nature of the right itself, i.e. that it is to be progressively realised, mean that the right is not violated by the State? The Maastricht principles provide some useful guidelines about the meaning of "progressive realisation". States are granted a margin of discretion in determining the means for implementing rights. Progressive realisation cannot be used as a pretext for non-compliance.[73] Social, cultural and religious reasons cannot be used to justify non-compliance. A State's non-compliance can either be due to an inability to comply or an unwillingness to comply. The burden is on the State to prove that the inability to comply is due to an inability beyond its control.[74] Budgetary allocations, for instance, may not necessarily be a reason of an inability to comply but rather of an unwillingness to reshuffle the budget.

With regards to the importance of the purpose of the limitation and the nature and the extent of the limitation, the effect of the PTSA creates a competitive process for gaining admission to the State funded treatment centres and facilities. This limitation appears to be unintended, serving no purpose, apart from guarding state resources. There are many wider ramifications of a breach of section 27(1) in this context. The discussion below centres on one consequence: that for a pregnant illicit drug user not obtaining substance abuse treatment.

4.2 The pregnant illicit drug user

The consequences of not obtaining substance rehabilitation treatment as a pregnant woman are damning. The SACENDU report indicates that child-bearing women are more at risk of illicit drug use. These women are more likely to be unemployed and dependent on State funded treatment centres.[75] The child often presents with physiological and/or neurological damage.[76] Unfortunately, a child placed in such a situation has few, if any, legal remedies. The mother could be arrested in terms of the DDTA the use and/or possession of, and/or dealing in, illicit drugs. This would however, not remedy the harm suffered by the child, and may even separate a mother from her child. Furthermore, it may be difficult to impute delictual liability for harm suffered by the child as the mother may have lacked legal capacity due to intoxication. Furthermore, the foetus itself cannot be the bearer of rights.[77] Thus it can be concluded that no feasible legal remedy exists in South African law for the child who has suffered harm in

[72] S 27(2) of the Constitution.

[73] Maastricht Guidelines at 694.

[74] Maastricht Guidelines at 696.

[75] See 2.1 above for a broader discussion.

[76] See 2.1 above for a broader discussion.

[77] *S v Mshumpa and another* 2008 (1) SACR 126 (E) at para 64.

utero due to the mother's use of illicit drugs. It seems unfair and unjust to allow a child who has suffered such harm to continue with her life carrying the seal of another's fault.

In this scenario, liability may be imputed to the State for failing to exercise due diligence. The term "due diligence" in the international human rights context, was first developed by the Inter-American Court on Human Rights in the case of *Velasquez Rodriguez v Honduras.*[78] The Court in that matter found that where rights are guaranteed, the state is obligated to exercise due diligence to ensure their fulfilment.[79] The State must prevent, investigate and punish any violation of rights. The existence of a legal system is not enough to satisfy this requirement; the government must conduct itself in a manner which ensures the enjoyment of rights.[80]

In this case, the due diligence standard applicable is the State's obligation to ensure that a child does not suffer consequent harm after birth due to its mother's antenatal use of illicit drugs. The State is required to prevent such a situation from occurring, investigate the occurrence of the harm and punish any violation of rights.[81] As a party to the Convention on the Rights of the Child (1989),[82] South Africa is bound to ensure the life, survival and development of the child[83] as well as to give the child's best interests primary consideration.[84] It is these rights of the child, which have corollary provisions in domestic law[85], which are violated. It is clear that by failing to provide sufficient and free of cost substance abuse treatment centres and facilities, the State has not conducted itself in a manner which ensures the enjoyment of rights. It has thus not acted with due diligence. Thus a failure of the State to provide access to healthcare in a seemingly isolated zone can have repercussions for State liability in other areas. Going forward, the next part of the article explores possible legal and extra-legal means to remedy the breach.

5 CONCLUDING RECOMMENDATIONS

Due to the interrelated nature of rights, this article has sought to show how a failure by the State to provide access to healthcare in the form of sufficient and State funded substance abuse treatment centres, can have repercussions for State liability in other areas, such as a failure to act with due diligence in preventing harm to the child born after illicit drug use. No remedy exists in the law for such a child born alive. It can however be shown that the State has failed to exercise due diligence in preventing,

[78] 1988 Inter-Am. Ct. H.R. (ser. C) No.4.

[79] *Velasquez Rodriguez v Honduras* at para 172.

[80] *Velasquez Rodriguez v Honduras* at para 172.

[81] Committee on the Rights of the Child "General Comment no. 13: the right of the child to freedom from all forms of violence" at 4. Available at http://www2.ohchr.org/english/bodies/crc/docs/CRC.C.GC.13_en.pdf (accessed 4 September 2014).

[82] United Nations, The Convention on the Rights of the Child as adopted in 1989.

[83] Art 6.

[84] Art 3(1).

[85] The best interests of the child principle is enunciated in s 28(2) of the Constitution and s 9 of the Children's Act 38 of 2005.

punishing and investigating the violation of the child's rights to life, survival and development, and of its best interests being given primary consideration.

The Department of Social Development, being a key player in the enforcement of the NDMP, should develop a programme targeted at illicit drug use by pregnant women in order to understand and research the prevalence of the problem. While the harmful effects of Foetal Alcohol Syndrome are well known, more must be done at State level to research the effects of illicit drug use during pregnancy. Women and men should be educated in the harmful effects of illicit drug use during pregnancy. Presently, it does not appear as if this issue is on the State's agenda.

However, in order to address the source of the problem, more State funded substance abuse treatment centres must be established. Presently, they are few and far between due to the State's minimal obligation to establish one State funded treatment centre in each province. The highly competitive application process means that often addicts have to wait up to six months to gain admission to a centre. This has disastrous consequences for those in desperate need of treatment. Furthermore, these centres are located in city centres, making access difficult for those living in outlying areas. There are numerous private treatment centres nationwide, but their high tariffs ensure that access is a privilege of the rich. More budgetary allocations should be made by the Departments of Health and Social Development for the creation of free of cost substance abuse treatment centres. The PTSA Act must be amended to reflect that the State is obliged to build more than one treatment centre in each province, depending on the needs of the province. Women living away from city centres should be given better access to substance abuse treatment centres.

Another integrated solution is based on the established link between mental disorders and pre-and post-natal women.[86] Maternal mental illness levels are higher in low income and informal settings in South Africa.[87]Studies also show that there is an increased likelihood of mothers self-medicating with alcohol or illicit drugs.[88] Meintjes and others suggest that the State should include mental health screening of all pregnant women accessing public maternity care. This form of intervention is cost effective as existing resources and services are used. It is also feasible as the mental health screening suggested is not time consuming and can be conducted effectively, since mental illness is usually treatable.[89] Once a pregnant woman has been positively identified as a sufferer of mental illness and as an illicit drug user, there is no guarantee that this person will gain access to a treatment centre. Thus the integrated services suggested by Meintjes are part of a broader solution to maternal drug addiction.

Illicit drug addiction is a health issue which can be cured with treatment. It cannot be cured with advertisement campaigns aiming to create awareness around the issue or the sanctions of the criminal justice system. Budgetary resources need to be

[86] Meintjes *et al* "Improving child outcomes through maternal mental health interventions" (2010) 22(2) *Journal of Child and Adolescent Mental Health* 73.

[87] Meintjes *et al* (2010) at 73.

[88] Meintjes *et al* (2010) at 74.

[89] Meintjes *et al* (2010) at 78.

allocated for the purpose of creating sufficient substance abuse treatment centres. A failure to reshuffle the budget will be interpreted as an unwillingness to comply with Article 12 of the ICESCR and section 27(1) of the Constitution, rather than as an inability to comply. Given its recent ratification of the ICESCR, South Africa should take heed.