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South Africa's Life Esidimeni Disaster and the Institutional Corruption That Opened the Door to It

SASHA STEVENSON

Abstract

In mid-2015, the Gauteng Department of Health in South Africa canceled a contract with Life Esidimeni, a subsidiary of a large hospital group that ran four facilities housing almost 2,000 people with mental illnesses. The termination of the contract and the chaotic transfers of people that followed resulted in enormous suffering and 144 deaths. Mental health care users died in conditions of neglect—emaciated, dehydrated, unmedicated, and with bedsores and gangrene. Their rights to health care services, to dignity, and to life were violated. The Life Esidimeni disaster occurred within the context of institutional corruption: a systemic and strategic influence that undermines an institution's effectiveness by weakening both its ability to achieve its purpose and the public's trust in it. Considering the institutional corruption that was the context for the Life Esidimeni disaster—including the overlap of political and administrative functions and the drive to save money, disguised as a desire for deinstitutionalization—this paper examines the public and legal processes undertaken to expose the disaster, to secure accountability, and to begin to deconstruct the conditions that allowed one of South Africa's most shameful human rights violations of the democratic era.

Sasha Stevenson is executive director of SECTION27, Johannesburg, South Africa.

Please address correspondence to the author. Email: stevenson@section27.org.za.

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Introduction

South Africa's 30 years of democracy have seen impressive progress in improving lives, and devastating illustrations of a government whose institutions have been corrupted, causing huge suffering and human rights violations. The Marikana massacre of 2012 saw 34 protesting miners killed by the South African Police Service to protect the interests of a platinum mining company. The Stilfontein disaster in 2024 saw men being trapped underground and starving, in some cases to death, in the government's attempt to stop mining in abandoned mines near Johannesburg.

Life Esidimeni, despite its name meaning "place of dignity," will always be remembered for the deaths of 144 mental health care users. They died in circumstances of severe neglect—emaciated, dehydrated, unmedicated, and with bedsores and gangrene. Many mental health care users died alone, their families not having been informed of their move out of Life Esidimeni and into so-called nongovernmental organizations (NGOs) that were incapable of caring for them.

The widescale violation of the rights of mental health care users occurred despite South Africa's human rights framework—a legal shift from its apartheid past to one of the world's most progressive constitutions, protecting civil and political as well as socioeconomic rights. South Africa's ratification of the African Charter on Human and Peoples' Rights in 1996 and the Convention on the Rights of Persons with Disabilities in 2008 indicated its intention to align with global rights protections—an intention that was far from met in this case.

The disaster must be seen as a large-scale human rights violation within the context of institutional corruption: caused by inappropriate political involvement in the administration of health and the drive for cost-saving, disguised as deinstitutionalization.

While the institutional context in no way removes individual liability for the deaths, it did open the door to the violation of the human rights of particularly vulnerable people who were unable to speak for themselves. And this requires attention to protect the many people whose health and lives are in the hands of an institutionally corrupt state department.

The Life Esidimeni disaster

In October 2015, the Gauteng Department of Health notified Life Esidimeni (a private provider of chronic mental health care services) of its intention to terminate the contract between the parties, giving the contractually required six months' notice. People at Life Esidimeni had been diagnosed with a range of mental illnesses, intellectual disabilities, and sometimes also physical conditions. Diagnoses included schizophrenia, schizoaffective disorder, traumatic brain injury with cognitive impairment, severe intellectual disability, cerebral palsy, and bipolar mood disorder, among others. Around 1,700 mental health care users lived at one of the Life Esidimeni facilities at the time of the contract termination.[1]

As early as June 2015, concerns about plans to reduce the number of beds at Life Esidimeni by 200 each year (not, at that stage, to cancel the contract altogether) had been raised by the South African Society of Psychiatrists (SASOP). SASOP had argued that there were insufficient alternative options for the mental health care users at Life Esidimeni and warned of a "revolving door" of care, in which users who had been stable at Life Esidimeni would relapse and would need to be re-hospitalized in acute psychiatric units and specialized hospitals. SASOP also cautioned about longer stays in hospitals for mental health users without step-down facilities and warned further of a cycle of homelessness and incarceration.[2]

What SASOP did not know, until the termination of the contract was made public, was that the government intended not merely to reduce beds but to move all mental health care users out of Life Esidimeni facilities within just six months.

Once the full shut-down plan became known, these concerns and objections were echoed by others. The clinical heads of Gauteng's psychiatric hospitals wrote a warning to the head of the Gauteng Department of Health and its director of mental health, stating that they had grave concerns

because most of the mental health care users in Life Esidimeni, who had previously been transferred from the psychiatric hospitals they led into Life Esidimeni, would not be fit to be discharged within the next six months; existing community-based care facilities were full; and promised renovations to hospital wards to accommodate further mental health care users would take several years.[3]

Families of mental health care users, the South African Depression and Anxiety Group, and the South African Federation for Mental Health, working with SECTION27 as their lawyers, all raised concerns. When multiple meetings produced no results, the concerned parties litigated against the Gauteng Department of Health, asking for the appointment of curators *ad litem* to protect the interests of the mental health care users. The department refused to consent to this appointment, but the case was settled out of court, where the department agreed, among others, to consult with families about the move of mental health care users and to endeavor to ensure that Life Esidimeni residents would, at new facilities, receive health and other services of no lesser quality than the services rendered at Life Esidimeni.

Between January and March 2016, a series of meetings was held between the department and stakeholders. The department still failed to disclose any plans or budgets for the move, appeared not to be assessing mental health users or NGOs, and quoted different numbers of users at each meeting.

In March 2016, at one of these meetings, it emerged that the department intended to move 54 people from Life Esidimeni to Takalani Home. Takalani Home was classified in the department's own documents as a facility for children with severe or profound intellectual disabilities. None of the people that the department intended to move to Takalani Home was a child, and the mental health care users had a variety of mental illnesses, including dementia and schizophrenia.

The families and their allies launched a second court action, aimed at stopping the move to Takalani Home and securing access to the information that the health department had been withholding throughout months of meetings.[4]

The department argued that Takalani Home was no longer a facility for children only and that all people who were being moved had been assessed and no longer needed mental health care. They would have been sent home but they did not have families. The court could not have known, as became evident later, that most of these statements were false. It ruled in favor of the Gauteng health department.[5]

Following the court decision, the department increased the pace of the project to remove everyone from Life Esidimeni and, by June 2016, had moved 1,711 people out of the facilities.[6] Most families were not contacted prior to the moves, and many had to scramble for days or even weeks to find the new locations of users by calling or visiting multiple NGOs across the province.[7]

Most of the NGOs had been recently established or, like Takalani Home, had recently undergone a change in scope. Many of the licenses issued by the health department to NGOs reflected inaccurate information, and most NGOs were not suitable for mental health care users. There were shortages of beds, food, and staff; a lack of security; and no ability to dispense medicines, twinned with difficulties accessing medicines from clinics. It was a cold winter, and the NGOs did not have sufficient heating or blankets.[8]

The member of the executive council (MEC) for health, Qedani Mahlangu, was deeply involved with the implementation of the project, despite her role as a political head and non-expert (she had qualifications in education and finance). She was the one who made the decision to terminate the contract and, later, to extend the notice period from six to nine months.[9] She chaired project meetings every two weeks and issued instructions.[10] She set deadlines and received reports on progress. The director of mental health in the Gauteng Department of Health, Makgabo Manamela, was not meant to be managing the project (she was assigned as deputy project manager), but in effect she managed the process. She was also involved in the moves, visiting NGOs and moving beds to increase the number of mental health care users who could be accommodated in each place.[11] She used the threat

of the MEC's instructions to secure compliance by health department staff—a threat that was effective given that many officials were intimidated by and unwilling to stand up to the MEC.[12] The MEC prided herself on demanding that people in her department "do their jobs." This ordinarily welcome accountability stance, so lacking in many government departments in the country, resulted not in excellence but in muted compliance and fear. Manamela, a psychiatric nurse by training, failed to exercise her professional expertise to guide the implementation of the project or to advocate for extended time frames that could have rendered it safer.

There were three primary reasons given for moving mental health care users out of Life Esidimeni: the need to reduce costs; the problem with renewing a contract many times over many years; and the imperative to deinstitutionalize mental health care users.[13]

Leadership and officials within the Gauteng Department of Health were informed of the problems with both the conception and the implementation of the project but failed to take any action to protect the mental health care users.

Part of the reason for the poor conditions in NGOs, it turned out, was that the department did not have the required contracts with these institutions before moving people into them. Without these contracts, the department was unable to pay the NGOs. As a result, NGOs experienced delays of several months before they received state funding. Because many of the NGOs were new and did not have financial reserves, this delay in funding meant that NGO owners had to secure personal loans to enable their institutions to feed mental health care users.[14] NGO owners testified to being coerced to accept more users than they could handle, or people with comorbidities that they were unable to manage.

Almost immediately, mental health care users started to die. Deborah Phehla died within three days of being moved into Takalani Home. She died due to aspiration of blood from a perforated larynx, caused when she swallowed paper, cardboard, and plastic that was stored in the room she stayed in. Her periodical report from Life Esidimeni had noted that if not properly supervised, Phehla would eat rubbish.[15]

Over the following months, 144 people died. The causes of death included severe malnutrition, dehydration and gangrene, asphyxia due to aspiration of blood or food, and pneumonia.[16] While not all deaths were recorded as unnatural, what is clear is that mental health care users died in conditions of severe neglect. There was insufficient food, dehydration, cold and cramped conditions, and, in some cases, a lack of medication, poor access to physical health care services, and little or no access to mental health care services. Many mental health care users died without having seen their families, who did not know where they had been taken. Groups of friends from Life Esidimeni were separated. The "caregivers" being paid for their care often lacked the expertise and experience to meet the needs of the mental health care users. Moreover, in many cases, medical files had been lost in transit, meaning that even qualified caregivers would not have known what the users' specific needs were.[17]

It took many deaths for health authorities to start taking the pleas of families and the demands of activists seriously. After the MEC responded to a question in the provincial legislature on September 13, 2016, stating that 36 mental health care users had died (while underplaying the seriousness of her admission), the minister of health and others requested an investigation by the Health Ombud.[18]

The Health Ombud's investigation lasted less than six months. In February 2017, he announced that he had established that there had been 94 deaths of mental health care users and that he suspected more.[19] The Health Ombud's investigation had precipitated action by the minister of health, including the relocation of some mental health care users from particularly dangerous NGOs. Nonetheless, the investigation report included recommendations for securing the safety of surviving mental health care users, accountability for those responsible, redress for the rights violations experienced, and reform to the mental health care system to prevent recurrence.[20]

The years that followed have seen various

processes designed to better understand what happened and why, and to seek justice for the victims of the Life Esidimeni disaster.

The first process was an arbitration. The arbitration agreement noted that the government did not dispute its liability for the deaths, nor did it dispute that the Life Esidimeni deaths were not natural, despite being recorded as such on death certificates. The agreement provided for the ordering of equitable relief by an arbitrator, who was to be appointed by agreement between the parties.[21]

The arbitration was held over the course of 43 days, with an additional two days of legal argument. Sixty witnesses gave evidence, including 12 senior state officials, five middle-management government employees, one senior police officer, the managing director of Life Esidimeni, three NGO owners and managers, six expert witnesses, and 31 affected family members. Former deputy chief justice Dikgang Moseneke was appointed as the arbitrator. Justice Moseneke found that the mental health care users and their families had suffered violations of their human rights, and he issued an award that included requirements for formal apologies, the development of a mental health service recovery plan, and the payment of damages, including constitutional damages.[22] Notably, little of the mental health service recovery plan has been implemented to date.

Despite an earlier attempt to secure a police investigation, it was only during the arbitration that the police started investigating in earnest. After more than a year of investigation and consideration of prosecution by the National Prosecuting Authority, a decision was made in 2019 not to prosecute but instead to refer the matter for an inquest.[23]

A judicial inquest was held over 130 court days from July 2021 until November 2023. All current and former government officials were legally represented in the inquest at the state's expense. Most NGO owners and managers were represented by Legal Aid South Africa, also at the state's expense. By contrast, 44 families of mental health care users were represented by SECTION27, a public interest law center funded through philanthropy, while four families were represented by AfriForum.

Judge Mmonoa Teffo of the Gauteng High Court in Pretoria found that the deaths of nine of the mental health care users were unnatural and were caused by the negligent conduct of Gauteng health officials Mahlangu and Manamela.[24] Judge Teffo's finding opened the possibility of prosecution by the National Prosecuting Authority. At the time of writing, the National Prosecuting Authority had not made a decision on prosecution.

In addition to compensation through the arbitration and attempts at criminal accountability through the inquest, each of the health care workers in positions of leadership within the Gauteng Department of Health were referred to their professional bodies for professional sanction. To date, no such sanctions have been issued.

Human rights violations

In the first paragraph of the Life Esidimeni arbitration award, Justice Moseneke describes the award as "a harrowing account of the death, torture and disappearance of utterly vulnerable mental health care users in the care of an admittedly delinquent provincial government."[25]

The human rights violations in the case were extensive and contrary to South Africa's international, regional, and domestic legal undertakings.[26]

The South African Constitution protects everyone's inherent human dignity, right to life, freedom and security of the person, and right not to be tortured or treated in a cruel, inhuman, or degrading way.[27]

The NGOs to which mental health care users were transferred were "treacherous" and were "properly dubbed death traps or sites of torture."[28] Food was insufficient or of bad quality, water was not provided to one mental health care user for fear that he would urinate on himself, medication was unavailable, security was inadequate, and NGOs were overcrowded and sometimes dirty.[29] The inadequacy of the subsidies paid to NGOs and the absence of other available funding to support the care of the mental health care users was a significant cause of these poor conditions. As described above, most NGOs received their first payments

only weeks or months after they received mental health care users, due to problems with their service-level agreements. That people, but not money, could be transferred to NGOs where the terms of their care were yet to be agreed in writing is telling of the priorities of the Gauteng Department of Health.

The human rights violations suffered by the mental health care users who were moved out of Life Esidimeni included violations of their rights to life, to dignity, and to freedom and security of the person.

Mental health care users also suffered violations of their rights under section 27 of the Constitution, regarding access to health care services.

Justice Moseneke described, from evidence before the arbitration, the chaotic process of the moves of mental health care users out of Life Esidimeni, including the fact that individuals were not assessed by the multidisciplinary teams that ought to have been involved in the project, meaning that their individual needs were not taken into account. They were moved "without useful or any medical records; without access to clinical and other medical care and without access to appropriate or prescribed medication."[30]

He noted the inconsistency between South Africa's legal obligations and their implementation, finding that

> *since 1994 our State has erected a globally admirable and compliant regulatory regime for the care of mental health care users. Its provisions are by and large in sync with international human rights and mental health care norms of a very high order. But what stands out is the breadth and depth and frequency of the arrogant and deeply disgraceful disregard of constitutional obligations, other law, mental health care norms and ethics by an organ of state, its leaders and employees.*[31]

While Justice Moseneke did not address the right to health in as much detail as the other rights violations, he nonetheless included it in his reasoning for the award of constitutional damages—one of the first such awards in South Africa's constitutional democratic era.

It is difficult to imagine a more egregious example of the violation of the right to health than the Life Esidimeni disaster. This was a clear case of retrogression: the unlawful reduction in rights realization. Mental health care users who had received appropriate care at Life Esidimeni had such care removed, with terrible consequences.

This occurred in spite of the constitutional and international principle against deliberately retrogressive measures without careful consideration and justification by reference to the totality of the rights and the resources available.[32]

In the context of limited resources and inadequate provision of health care services to many people in the country, the mental health care users at Life Esidimeni were receiving the mental and physical health care that they required. That these services were taken away, to be replaced with conditions likened to torture, is a clear violation of their right to health.

The Life Esidimeni disaster in the context of institutional corruption

While there can be little doubt that individuals within the Gauteng Department of Health should be held personally criminally liable for their role in the Life Esidimeni disaster, the disaster took place in a particular institutional context, some of which was in fact fostered by the individuals concerned. This institutional context is one of institutional corruption.

The original definition of institutional corruption comes from Lawrence Lessig, who finds that "institutional corruption is manifest where there is a systemic and strategic influence which is legal, or even currently ethical, that undermines the institution's effectiveness by diverting it from its purpose or weakening its ability to achieve its purpose."[33] A classic example of institutional corruption is the complex problem of political campaign funding. While funding is required, it can create conflicts of interest that erode the functioning of a political actor and the trust of their supporters.

Dennis Thompson describes institutional corruption as being equivocal (the corruption may

benefit the institution while undermining it by exploiting legitimate institutional practices that provide benefits to the institution and more broadly); impersonal (the individuals involved need not have corrupt personal motives); and generalizable (it is not only government but also other sectors or industries that may be institutionally corrupt).[34] This theorization has various benefits, including shifting the focus from deterring or removing corrupt individuals to changing the rules and procedures of the institution that open it up to institutional corruption. It also explains why institutional corruption is often difficult to see—because it can be so closely connected to the legitimate procedures and practices of an institution, its agents are not seen, and do not see themselves, as participating in corruption at all.[35] Thompson further notes that institutional corruption "manifests as a structural practice that has contemporaneous effects, of which the agents may be aware but which they have reason to regard as part of a legitimate (though flawed) process."[36] He notes that "individuals in a corrupt institution may still be motivated to serve the institution as best they can and may be following practices … that under a general description are legitimate parts of the democratic process."[37]

While some theorists of institutional corruption argue that corrupt individual motivation must be present for institutional corruption to occur, the majority find differently.[38] Institutional corruption, then, is quite different from corruption for personal gain, and rooting it out requires dealing with the systemic influences that created it.

The framing of institutional corruption is helpful in the case of Life Esidimeni because it explains how an organization tasked with protecting the public interest—in this case, the Gauteng Department of Health—could be undermined by influences and activities that, while not necessarily harmful, immoral, or illegal in themselves, lead the organization to systematically diverge from its role.[39]

The institutional corruption context of the Life Esidimeni disaster was one of the active and inappropriate political involvement in the administration of health, together with a drive to save money, which in this case was disguised as deinstitutionalization. These factors combined to create the conditions in which mass deaths occurred. And if they could be remedied, the Gauteng Department of Health would be a much stronger institution, able to prevent future violations of health and other rights.

Intrusion of political actors into the administrative realm

The Constitution envisages roles for both political and administrative leadership at the national and provincial levels. The model requires that political principals define policy and oversee implementation. Officials reporting to them, starting with the head of department, implement policy within a legal framework and should lend subject-matter expertise to such implementation.

Political leadership is provided for in section 133, which lays out the appointment, by the premier (the member elected by the provincial legislature to lead the provincial executive) of an executive council, the members of which are responsible for the functions of the executive assigned to them by the premier. The premier appoints MECs, assigns them powers and functions, and may dismiss them.[40] Section 195, in turn, requires a public administration that is professional, effective, impartial, and developmentally oriented.[41] Such a public administration is not the realm of politics.

Sarah Meny-Gilbert and Ryan Brunette argue that the "assertion of strong political control over [public administration] appointment processes gave, in the late 1990s and early 2000s, the new democratically elected government the ability to transform the composition and orientation of the apartheid-era civil service."[42] However, the overlap between the political and the administrative arms has created space for patronage and intersecting functions.

The total separation of politics and administration will never be possible. As Joel Pearson and Thatshisiwe Ndlovu note, "the daily work of state officials involves choices over the distribution of value—an exercise of power and politics."[43] However, public administration must be insulated from

inappropriate levels of interference.

Public administration in Gauteng was not insulated from inappropriate levels of political interference. MEC Mahlangu was favored by the African National Congress in the province and was proud of her budget-management efforts in the health department, which had previously been experiencing growing accruals. She was also proud of her tough stance on performance, at odds with a civil service culture characterized by poor performance and limited accountability.

The way that this played out was to create a culture of fear. During the arbitration and the inquest, various officials (including the head of department) admitted to fearing the MEC.[44] The MEC's threats to "do your job or you will be fired" were taken to require compliance even with what officials recognized as being unlawful orders.[45] When the project manager asked for an extension on the notice period for the closure of Life Esidimeni, the MEC asked him in a project meeting if he was a spokesperson for Life Esidimeni.[46] This had the effect of silencing further protest and was raised by multiple officials as evidence that no one could push back against the wishes of the MEC.

The MEC's chairing of twice monthly project meetings meant that the pressure that she exerted was constant and direct, but also that the people within the department with expertise in mental health care were not managing the process. Instead, the political head, with no expertise in health, was doing so.

The lack of insulation of the public administration from politics, and a powerful political head in a department of civil servants that would not stand up to her, allowed the MEC's outsized political influence to overpower and divert the work of the department. It was in this context of institutional corruption that a mental health project, championed by the MEC, could be carried out against the interests of mental health care users.

Money-saving disguised as deinstitutionalization

Inevitably facing resource constraints, health departments will always need to use money wisely. The need to save money, however, cannot be allowed to divert or undermine the role of the department. In this case, the department instituted what it called a deinstitutionalization project but was in fact a cost-cutting exercise. None of the rights-affirming protections of deinstitutionalization were in place. The drive to save money created an institutional context that saw the Gauteng Department of Health deviating from its role of providing care.

Deinstitutionalization is the relocation of people from institutional settings into their communities and the closing of institutional beds to prevent further admissions.

General Comment 1 of the United Nations Committee on the Rights of Persons with Disabilities reflects the long history of the denial of legal capacity to persons with disabilities, along with the impact of such denial, particularly on people with cognitive or psychosocial disabilities. The general comment provides that

> *in order to comply with the Convention [on the Rights of Persons with Disabilities] and respect the human rights of persons with disabilities, deinstitutionalization must be achieved and legal capacity must be restored to all persons with disabilities, who must be able to choose where and with whom to live.*[47]

The drive for deinstitutionalization has gained widespread support around the world. While there are concerns about the argument that institutionalization and involuntary treatment are inappropriate in any circumstances, recognition of the well-documented abuse of people with mental illnesses and the overuse of institutionalization in many contexts makes clear the need to deinstitutionalize.[48]

South Africa has historically over-institutionalized mental health care users, and deinstitutionalization has been implemented in South Africa since the end of apartheid in 1994. The number of chronic mental health care beds in Gauteng Province decreased from about 70 per 100,000 residents in 1994 to about 35 per 100,000 in 2004.[49]

The Mental Health Care Act promotes mental health care in the least restrictive environment

possible.[50] To support this aim, the National Mental Health Policy Framework and Strategic Plan 2013–2020 envisages the deinstitutionalization of some mental health care users following the development of community-based services. The document warns that "deinstitutionalization has progressed at a rapid pace in South Africa, without the necessary development of community-based services. This has led to a high number of homeless mentally ill, people living with mental illness in prisons and revolving door patterns."[51]

The approach laid out in the policy accords with the World Health Organization's guidance that "successful deinstitutionalization requires comprehensive community-based services, sufficient financial and structural investment, and a shift in mindsets and practices to value people's rights to community inclusion, liberty and autonomy."[52]

Ray Lazarus, formerly of the Gauteng Department of Health, had argued almost two decades before that it was "essential to retain a certain minimum number of chronic beds and the resources to adequately care for a minority of patients who are very difficult to manage in the community."[53] Mvuyiso Talatala, who was the head of SASOP at the time of the Life Esidimeni disaster, noted that the mental health care users in Life Esidimeni were often severely mentally ill and would be difficult to discharge.[54] Talatala noted that deinstitutionalization was not appropriate for everyone and that a small number of mental health care users would always need chronic care of the kind provided at Life Esidimeni.

Given what deinstitutionalization requires and the situation in South Africa at the time, how were the rapid moves of mental health care users from Life Esidimeni into what were effectively smaller and less well-resourced institutions framed as deinstitutionalization? The answer is that the project was never about deinstitutionalization and so none of the protections of a deinstitutionalization project was implemented. Instead, it was an attempt to save money in the guise of a deinstitutionalization process.

This is evident in the lack of preparation of the mental health care users themselves and of the NGOs meant to receive them. The usual process—including assessing the mental health care user and allowing repeated and progressively lengthened stays in the new community-based environment to assess appropriateness—was not carried out. Instead, mental health care users were discharged despite what their periodical reports indicated and without previously having visited the NGOs to which they were transferred. People were moved in groups rather than according to their individual needs, and most of the 1,711 people were moved in a period of three months.

Many of the NGOs were still in the process of renovation after the moves of mental health care users. They did not have the staff to provide appropriate care, and, importantly, while the plan had been for NGOs to access medicine for the mental health care users from local clinics, there were no resources or protocols in place to enable the clinics to deal with the increased demand for assistance from people with complex needs. Many of the mental health care users were transferred to NGOs far from their families and communities.

Most tellingly, rather than the money following the mental health care users into deinstitutionalized community-based care, there was an increase in the allocation to psychiatric hospitals and very small allocations to the NGOs that were tasked with caring for the majority of the mental health care users.[55]

Deinstitutionalization is neither easy nor inexpensive. Global experience and numerous studies have shown that moving mental health care users from institutions should not be used to save money because this can result in abuse, increased hospital admissions, and early mortality.[56] In fact, the World Health Organization recommends double budgeting for the period of deinstitutionalization to ensure that both the institutions and the replacement care are properly funded.[57] Such an approach could assist in catering to the perennial problem of underinvestment in mental health.[58]

The use of the term "deinstitutionalization" to justify the mass transfer of mental health care users into dangerous places, often far from their families' homes, was an abuse of an ordinarily

rights-protective and rights-enhancing mechanism for mental health care users. It further disguised a shift of responsibility for care away from the state and onto mental health care users themselves, their families, and the unwitting owners and operators of NGOs that were offered small sums of money to provide extensive care without adequate support.

The disguise of a cost-saving exercise with a "deinstitutionalization" project is a clear example of institutional corruption. While the Gauteng Department of Health, like any health department, will always need to find ways to save costs, the need to do so cannot be met through misrepresentation and in a way that results in it deviating from its role of providing appropriate care.

Attending to the institutional corruption that made the Life Esidimeni disaster possible

The political overreach into the realm of health services provision, together with the drive to save money no matter the consequences, combined to create a weakened, institutionally corrupt department that was diverted from its proper role. This department was the context for individuals in leadership taking decisions and acting in a way that killed 144 people and caused the suffering of many more.

Institutional corruption requires change to the rules and processes of an institution, to rebuild trust and restore the institution's ability to perform its function. If the institutional context laid the foundations for the Life Esidimeni disaster, what needs to change to prevent further violations of human rights?

Leadership

It is frequently emphasized that good leadership is a prerequisite for a health system that meets the needs and realizes the rights of the people who rely on it.[59] Consistently good leadership has been sorely lacking in the Gauteng Department of Health for some time—there have been nine MECs and nine heads of department between 2009 and 2025.

Good leadership requires the prevention of inappropriate political interference in health. The Constitution provides for the political-administrative division of powers and responsibilities, but the reality has long been different.

Part of the solution must be for the right people to be appointed to political leadership. As a sector that is particularly prone to corruption, and one whose work so directly impacts rights realization, pressure needs to be put on the government to appoint better political leaders in health.[60]

Perhaps the more important element, however, is for the civil service to be professionalized and members to be empowered to act within their areas of expertise and to, where necessary, push back against inappropriate political interference. There have been moves in this direction, including through the publication of the National Framework Towards the Professionalization of the Public Sector.[61] The test of government's commitment to a competent and rights-protecting public service will be whether this national framework is implemented.

Commitment to human rights

Lazarus suggests that "to counter paternalistic and overly cautious attitudes towards the care of people with mental disorders, it is essential to maintain a focus on human and patients' rights, and to persistently challenge entrenched attitudes and practices in this regard."[62]

If the Life Esidimeni disaster demonstrates anything, it is the need to entrench human rights in health care, including mental health care.

Forefronting the dignity and equality of mental health care users begins to counter stigma and strengthen those pushing against institutional corruption to support rights. It illustrates the need to cater to each individual's needs, both within institutions and through deinstitutionalization processes.

Human rights framing, particularly in the South African context that recognizes both individual and collective rights, also allows for the interrogation of systems that themselves mete out violence and discrimination and hamper social justice.

Conclusion

The Life Esidimeni disaster must be viewed as a warning to health systems across the world. That this disaster happened does not mean (as has largely happened in South Africa) that all deinstitutionalization attempts must be stopped. It does mean, however, that deinstitutionalization should not be used as a cost-saving exercise. It also means that health system actors have been able to witness directly the effect of political overreach in health. This overreach cannot be allowed to continue or be mirrored in other settings.

The Life Esidimeni disaster was an example of more than individual suffering. It was an example of an institutionally corrupt health department that systematically failed mental health care users through political meddling and a drive to save costs in a way that harmed people. A commitment to human rights could have saved many lives.

In South Africa's constitutional democracy, such a recommitment is urgently needed. Without it, we risk the further entrenchment of institutional corruption in the Gauteng Department of Health and the repeat of the Life Esidimeni disaster in the years to come.

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