WHITE PAPER FOR THE TRANSFORMATION OF THE HEALTH SYSTEM IN SOUTH AFRICA:

SUBMISSIONS TO THE PORTFOLIO COMMITTEE ON HEALTH IN THE LIGHT OF INTERNATIONAL AND CONSTITUTIONAL HUMAN RIGHTS JURISPRUDENCE

THE COMMUNITY LAW CENTRE (UNIVERSITY OF THE WESTERN CAPE)

and

THE ANC WOMEN'S CAUCUS

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1. Introduction:

The inclusion of the right of access to health care services[1] in the South African Constitution[2] marks a major achievement for a country which has a history of a fragmented and discriminatory health care system. The recently released White Paper on Health[3] is the primary policy framework that seeks to give content to the constitutional right of access to health care services and, as such represents a significant milestone not only for the Department of Health but, also for South African society on the whole. The shift from the historical context in which health care was previously provided in South Africa, to the current constitutional recognition of the right of access to health care services as a fundamental right is a much welcomed one. It is accordingly critical that health policy operates in a manner that complements and provides substance to this fundamental constitutional right.

At the outset, the Community Law Centre and the ANC Women's Caucus wish to commend the approach taken by the Portfolio Committee on Health on the transparent and consultative way in which this policy is being compiled. A process of this sort will ultimately ensure a health policy that is truly reflective of the needs, dynamics, and perspectives of the country.

This submission seeks to provide a constitutional and legal framework within which health policy in South Africa should operate. It further seeks to identify gaps within the policy and provide suggestions as regards methods of addressing these gaps. Furthermore, in accordance with the

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[1] Section 27 of the Constitution provides:

(1) Everyone has the right to have access to -
 (a) health care services, including reproductive health care;
 (b) sufficient food and water; and
 (c) social security, including if they are unable to support themselves and their dependents, appropriate social assistance.
(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.

Furthermore, Section 28(1)(c) of the Constitution provides:

"Every child has the right to basic nutrition, shelter, *basic health care services* and social services."

Finally, Section 31(2)(d) of the Constitution provides:

"Everyone who is detained , including every sentenced prisoner has the right to conditions consistent with human dignity, including at least exercise and the provision, at state expense, of adequate accommodation, nutrition, reading material and *medical treatment*."

[2] The Constitution of the Republic of South Africa, Act 106 of 1996, hereafter referred to as 'The Constitution'.

White Paper's goal of equity, this submission intends to ensure that a gender as well as a race and class perspective is truly reflected throughout the entire policy of health. The content of the White Paper on Health will accordingly be assessed in the light of constitutional and international jurisprudence as well as the parameters laid down in the White Paper itself.

At the outset, it must be acknowledged that this submission focuses primarily on the legal and constitutional requirements for engendering the White Paper on Health, as opposed to providing a comprehensive critique of the entire document. It is both our hope and belief that the remaining areas will be adequately addressed by Organizations and individuals with expertise in such areas.

2. The Framework within which the White Paper on Health Should Operate:

2.1. The Relationship between the Right of Access to Health Care and other Civil and Political Rights:

It is important that the White Paper on Health recognize that although there is specific constitutional recognition of the right of access to health care services, a failure on the part of the state to actually implement this right would result in not only a violation of the right itself but, also has implications for many of the civil and political rights entrenched in the Constitution. For example, if women are not able to control their fertility, the likelihood of them being full participants in public life is severely diminished. In other words, women's ability to participate in all spheres of society and in all aspects of life in a meaningful way requires recognition of the need for attention to discriminatory health practices which force women into certain sex specific and confining roles.

It must further be acknowledged that providing access to health care services in a meaningful manner requires respect for many other constitutional rights such as the right of access to information and the right to education.

The right of access to health care services cannot be viewed in a vacuum since the proper and meaningful implementation of the right requires an adherence to other fundamental rights and

[3] White Paper for the Transformation of the Health System in South Africa, Notice 667 of 1997 - Hereafter referred to as the 'White Paper'.

similarly a violation of the right of access to health care services has ramifications for other fundamental rights. The point will be illustrated in the present section.

The Right to Life:

The Constitution provides for a right to life.[4] The right to life, one may argue, entitles individuals to appropriate health care services as the absence of such health care services may ultimately result in death, thereby violating the right to life.[5] Hence, the right to life would be violated by a failure on the part of the state to take measures in terms of health care to ensure the survival of a particular person or group of persons. For example, failure on the part of the state to provide safe abortion services results in the untimely deaths of many women. Thus, one could argue, a repressive abortion law would violate women's right to life.

Human Dignity:

The Constitution recognizes the inherent dignity of everyone and the right to have their dignity respected.[6] Ensuring access to health care services has significant implications for the right to human dignity and consequently a violation of the right to health could very well result in the human dignity of persons being impaired. Health policy and legislation should accordingly reflect a commitment to ensuring access to health care services in a manner that is consistent with the fundamental principle of human dignity.

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[4] Section 11 of the Constitution.

[5] It must be noted that this argument is subject to certain qualifications. As has been noted, the Constitution provides for a right of access to health care services which the state is obliged to provide progressively and within its available resources. Whilst the exact terminology of the section will be analyzed in greater detail at a later stage, for the present purposes, the argument is that should the state fail to provide the 'core minimum' of the right of access to health care services which results in the death of an individual, it is likely that the state could also be held responsible for a violation of the right to life of that individual. Furthermore, in terms of Section 27(3) of the Constitution, no one may be refused emergency medical treatment. Whilst clarity is required on the exact ambit and parameters of the term 'emergency medical treatment', for the present purposes, it must be noted that the state has an obligation to provide emergency medical treatment, which is subject to a more stringent level of enforcement in that it is not subject to the qualifications of 'progressive realization' and 'within its available resources.' Hence, should the state fail to provide such emergency treatment which results in the death of an individual, it is once more likely that the state could be responsible for violating the right to life.

[6] Section 10 of the Constitution.

The Right to Equality:

The fundamental right to equality is provided for in the Constitution.[7] The Constitution further expressly prohibits unfair discrimination on the basis of race, gender, sex, sexual orientation, pregnancy, marital status, culture, religion and ethnic group. It is accordingly vital that the provision of health care services take place in accordance with this fundamental right to equality. The Convention on the Elimination of All Forms of Discrimination Against Women also obliges States to eliminate discrimination against women in the protection of health.[8]

Freedom and Security of the Person:

The Constitution provides for a right to freedom and security of the person.[9] The section expressly prohibits any person from being tortured and [10] punished in a cruel, inhuman or degrading way.[11] In the course of ensuring access to health care services, it is accordingly vital that an individual is not tortured or treated in a cruel, inhuman and degrading way.

The constitutional section dealing with freedom and security of the person further provides for a right to bodily and psychological integrity,[12] which includes the right to make decisions regarding reproduction, to security in and control over their bodies and the right not to be subjected to medical or scientific experiments without their informed consent. In order to ensure security and control over one's body, to make decisions regarding reproduction as well as to ensure informed consent in the context of health care services, it is vital that individuals are accorded the necessary information and education as regards access to health care services as well as the relevant treatment. The absence of the necessary means to ensure informed consent as regards health care can accordingly violate the freedom and security of an individual.

Access to Information:

The Constitution provides for the right of everyone to access to information that is held by the state and any information that is held by another person and that is required for the protection and

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[7] Section 9 of the Constitution.

[8] Article 11 (1) (f), UN Convention on the Elimination of All Forms of Discrimination Against Women (1979), which South Africa has ratified in January 1996 and is accordingly legally binding.

[9] Section 12 of the Constitution.

[10] Section 12(1)(d) of the Constitution.

[11] Section 12 (1)(e) of the Constitution.

[12] Section 12 (2) of the Constitution.

exercise of any rights. [13] Such information may include access to health services, self-help and preventative health care. Furthermore, access to information is clearly a critical element to ensuring the informed consent of individuals as regards their health. The White Paper on Health should accordingly reflect the critical link between access to health care services and access to information.

The Right to Education:

In order to ensure informed consent as well as making informed decisions as regards an individual's health, it is not only important that the individual has the required information, but also the necessary level of literacy to understand such information. Hence, in providing access to information as regards health care, it is important that the high levels of illiteracy are taken account of and appropriate materials developed. Furthermore in the context of women's health, research has consistently shown that women's education strongly influences reproductive health, including infant survival and healthy growth of children.[14] The vital role of education in ensuring access to improved health care services should accordingly be taken account of in the development of health policy.

2.2. The Implications of International Instruments on the Right of Access to Health Care Services:

In interpreting the rights in the Bill of Rights which clearly includes the right of access to health care services, the Constitution obliges a court, tribunal or forum to promote the values that underlie an open and democratic society based on human dignity, equality and freedom, and to consider international law.[15] It further provides that foreign law *may* be considered.[16]

Hence, in examining the health policy, reference will be made to the Convention on the Elimination of All Forms of Discrimination Against Women and the Convention on the Rights of the Child, both of which South Africa has ratified and are consequently legally binding. Reference will also

[13] Section 32 of the Constitution.

[14] Cook and Fathalla, *Advancing Reproductive Rights Beyond Cairo and Beijing,* International Family Planning Perspectives, (1996) 22 at page 8.

[15] Section 39(1)(a) and (b) of the Constitution.

[16] Section 39(1)(c).

be made to the International Covenant on Economic, Social and Cultural Rights which South Africa has signed but not as yet ratified.

Similarly, reference will be made to both the Beijing Platform for Action and the UN International Conference on Population and Development, both of which represent political aspirations which South Africa has agreed to adhere to.

All of these international instruments will be referred to as they pertain to specific areas of health care that *are* discussed or that *should* be discussed in the White Paper on Health.

2.3. The Terminology Used in the Constitution in Protecting the Right of Access to Health Care:

As has been mentioned, Section 27 of the Constitution speaks specifically to the right of everyone to have access to health care services.[17] It is strongly recommended that the White Paper on Health locate its policy within the constitutional framework of the right of access to health care services. In so doing, the White Paper should take account of certain critical issues as regards the terminology used in the Constitution which has ramifications for policy pertaining to health care and accordingly will be briefly discussed in the present section.

Before examining the definition of "health care services," it is important to accord brief attention to the terminology[18] of the section which should inform the content of the White Paper. Firstly, it must be noted that Section 27 of the Constitution makes reference to a right of *access* to health care services as opposed to health care *per se*. This terminology makes it clear that the state has to provide merely the conditions for the individual to realize the right themselves as opposed to the state providing free health care on demand to everyone.

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[17] As has been noted already, the Constitution expressly acknowledges that the right of access to health care services includes reproductive health care services. Whilst the right of access to reproductive health care services will be dealt with in detail in the section that follows, for the present purposes, the aspects pertaining to terminology in the context of health care generally will be similarly applicable to the right of access to reproductive health care.

[18] For a cogent analysis of the terminology used in the section see, See Liebenberg, *'Fundamental Rights: Commentary on Chapter 3 of the 1993 Interim Constitution and Chapter 2 of the 1996 Constitution (Health Care)'* in Davis, Cheadle and Haysom (eds) Fundamental Rights in the Constitution (1997).

Secondly, it must be noted that the implementation of the right is subject to *progressive realization* as opposed to *immediate implementation*. Hence, whilst the Constitution ultimately seeks to be in a position to provide health care services to everyone, it recognizes that there are constraints to doing so immediately and hence obliges the state to take measures over a period of time and on a progressive basis to ultimately secure access to the right to everyone. The UN Committee on Economic and Social Rights has interpreted the phrase "progressive realization" to mean an obligation on the part of the state "to move as effectively and expeditiously as possible to securing the ultimate goal of providing health care services to everyone."[19] Hence, the measures reflected in the White Paper should clearly aim to accomplish this goal of ensuring access to health care services of all by moving as expeditiously as possible. Any unreasonable delay or any retrogressive measures in achieving access to the right of access to health care services will accordingly be in violation of the state's duty to implement this right.

Furthermore, in terms of Section 27(2), the state is obliged to take reasonable legislative and other measures to achieve the progressive realization of the right of access to health care. As the White Paper on Health represents the primary policy framework that seeks to give substance to the constitutional right of access to health care services, it is important that it constitute a reasonable measure in relation to the ultimate goal of providing access to health care services for everyone. The content of the White Paper will accordingly be assessed in the light of this constitutional right of access to health care services.

As has been noted Section 27(3) of the Constitution provides that no one may be refused emergency medical treatment. As this subsection is subject to neither the internal qualification of 'progressive realization' nor 'within its available resources,' it is clearly subject to a more stringent level of enforcement than the general right of access to health care services is. As such, the White Paper should accord special attention to the definition and parameters of emergency medical treatment.

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[19] UN General Comment No 3, Para 9.

2.4. The Types of Obligations that the Right of Access to Health Care Services Incurs on the State:

The accepted Hohfeldian concept of rights is clearly applicable in the context of health, as it is with all other rights. This conception of rights recognizes that for every right in law there is a corresponding legal obligation. Hence, since there is a constitutional right of everyone to access to health care services, there is a corresponding obligation on the state to take steps so as to provide such access. In analyzing the kind of steps that the state should take to ensure the right, it is

important that these obligations be viewed within the specific framework which was first proposed by Henry Shue, later elaborated on by Eide and currently encapsulated in the Constitution. Section 7(2) of the Constitution obliges the state to respect, protect, promote and fulfill the rights in the Bill of Rights. The rights in the Bill of Rights would clearly include the right of access to health care services and it is accordingly important that in the formulation of policy pertaining to the right of access to health care, this framework be adhered to. The right of access to health care services will accordingly be examined in the context of this framework, which , it is contended will serve as a clearer framework for the right of access to health care services to be enforced.

2.4.1. The Obligation on the State to Respect the Right of Access to Health Care:

The obligation on the state to respect the right of access to health care requires that the state refrain from undertaking any legislative or other measures that violate the people's rights of access to health care services. This duty will be violated if the state deprives people of access to the health care services that they enjoy or passes laws or engages in conduct which effectively denies or obstructs access to health care services or the state unfairly discriminates against an individual or a group in extending access to health care services.[20] It is accordingly important that the White Paper on Health ensures that the state's obligation to respect the right of access to health care services is respected.

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[20] For a detailed analysis of the obligations that socio economic rights incur on the state as well as an explanation on minimum core obligations, see Liebenberg, *Identifying Violations of Socio Economic Rights,* (1997) (Forthcoming) Law, Development and Democracy

2.4.2. The Obligation on the State to Protect the Right of Access to Health Care:

The obligation to protect the right of access to health care services requires that the state take measures so as to ensure that an individual's right of access to health care services is not violated by other more powerful groups or individuals in society. Examples of the state's obligation in this regard would entail the state taking measures to protect an individual's right of access to health care services in private clinics or the state discouraging the use of tobacco. In ensuring the protection of the right of access to health care services, the White Paper on Health should accordingly strive to protect access to health care services from other more powerful groups or individuals in society. In the light of this obligation, it is suggested that the White Paper include measures that protect an individual's right of access to health care services from other more powerful groups or individuals in society.

2.4.3. The Obligation on the State to Promote and Fulfill the Right of Access to Health Care:

The obligation on the state to promote and fulfill the right of access to health care services requires the state to take positive measures so as to ensure that people who do not currently enjoy access to the right of health services, are able to gain such access. It would essentially require that the state take those measures that are necessary to ensure the full realization of the right. This would include direct provision of services or resources necessary to ensure a minimum core content of the right of access to health care services, when individuals or groups are unable to secure those services or resources.[21]

2.4.4. Minimum Core Content of the Right of Access to Health Care Services:

In ensuring the minimum core content of the right of access to health care services, a critical question for the Department of Health in the formulation of relevant policy and legislation is to make an actual determination on exactly what constitutes its minimum core obligations as regards of the right of access to health care services. As this is a particularly underdeveloped area of socio economic rights in the international arena, it is clearly an area that requires extensive research and investigation prior to being reflected in policy or legislation.

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[21] Liebenberg, *Identifying Violations of Socio Economic Rights,* (1997) (Forthcoming) Law, Development and Democracy

On the subject, the UN Committee on Economic, Social and Cultural Rights has interpreted the International Covenant of Economic, Social Rights to impose a minimum core obligation to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights. In this regard, it has been noted that when the state fails, for example, to ensure access to primary health care, "it is *prima facie* failing to discharge its obligations under the Covenant."[22] Furthermore, in order for the state party to rely on a lack of resources to justify a failure to meet its minimum core obligations, the Committee has said that "it must demonstrate that every effort has been made to use all resources that are at its disposal in an effort to satisfy, as a matter of priority, the minimum core obligations."[23]

The approach taken in the White Paper which implicitly recognizes the need for minimum core obligations is endorsed. On the subject, the White Paper notes "The goal is to provide for an increase in the average number of Primary Health Care (PHC) consultations per person from a low baseline of 1,8 in 1992/3 to 2,8 by the end of the century and to 3,5 over the following 5 years. Priority will be given to the most under served areas and the intention is to bring the provision of PHC services for the poor 2/3 of the population up to the level of that for the better off 1/3 by the year 2000."[24]

In the context of minimum core obligations, the White Paper's undertaking to accord priority to under served areas is commended. However, it is suggested that in developing these minimum core standards, whilst the urban/rural, rich/poor divisions need to be taken account of, factors pertaining to particular hierarchies *within* these targeted groups are duly recognized. According to Eide, "as a minimum all governments should establish a nation wide system of identifying local needs and opportunities for the enjoyment of the economic and social rights and in doing so *they should identify in particular the needs of groups which have the greatest difficulties in the enjoyment of these rights*."[25] Within the South African context, an example of a group that experiences the greatest difficulties in gaining access to health care services are rural women and

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[22] Quoted in Liebenberg, *Identifying Violations of Socio economic Rights,* (1997) (Forthcoming) Law, Development and Democracy

[23] Quoted in Liebenberg, *Identifying Violations of Socio Economic Rights,* (1997) (Forthcoming) Law, Development and Democracy

[24] Para. 3.1, The White Paper on Health.

[25] Eide, *Realization of Social and Economic Rights and the Minimum Threshold Approach* Human Rights Law Journal (1989) 10 at page 46.

as such their particular interests need to be reflected in the formulation of minimum core obligations.

Jurisprudence on the subject of socio economic rights has further identified country specific thresholds measured by indicators measuring nutrition, maternal mortality, violence against women, infant mortality, disease frequency, life expectancy, income, unemployment and under employment and adequate food consumption. These thresholds might prove helpful to the Department of Health in further developing its minimum core obligations.[26]

Examples of what might be considered minimum core obligations in the context of access to health care would include, but are not limited to the adoption of national policy as regards access to health care services that is consistent with the Constitution, the creation of systems for monitoring the health status of the nation in a sex and race disaggregated fashion and the repeal of discriminatory legislation that would impede the access of health care services by certain vulnerable groups as well as the provision of basic primary health care services as is required by the International Covenant on Economic, Social and Cultural Rights.[27]

It further recommended that these minimum core obligations are constantly reviewed in the light of changing circumstances and accordingly amended or altered to reflect changing demographics.

It view of the aforegoing, it is clear that the state has certain obligations that it must adhere to in the implementation of the right of access to health care services. It is accordingly vital that the White Paper work within this accepted framework in developing its policy as regards the right of access to health care services. It is further suggested that in the development of minimum core obligations, account is taken of the aforementioned issues.

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[26] *ibid*

[27] Cited in Liebenberg, *Identifying Violations of Socio economic Rights,* (1997) (Forthcoming) Law, Development and Democracy

2.5. Towards a Definition of Health Care:

Whilst the White Paper on Health speaks to goals, objectives and strategies that are necessary for providing access to health care services,[28] it fails to provide a comprehensive definition as regards 'health care' itself. It is strongly recommended that in addition to locating the White Paper within the Constitution, that it provide for a comprehensive definition of health care which should inform the goals, objectives and strategies that are provided for in health policy.

2.5.1. The Importance of Recognizing Women's Health Within the Context of Health Care Services:

In defining the term 'health care,' it is important that the White Paper on Health accord due recognition to women's health. In so doing, it should acknowledge that whilst a definition of health can, on its face be gender neutral, the reality and practice has been that the right to health as well as health care has been biased towards men and male health needs and requirements. Whilst it is not being suggested that a gender specific definition of health care is required, the White Paper is urged to take account of the traditional male bias in the provision of access to health care services and accordingly make express reference to *strategies* necessary for ensuring women's access to health care services.

However, it is important women's health not be seen solely in terms of reproductive health when formulating such strategies. While reproductive health is a fundamental aspect of women's health, a women's health framework is a broader concept that looks at all aspects of women's health, not just those pertaining to maternity, child birth, child-rearing and reproductive health.

Neglect of women's health is pervasive on the grounds of sex as well as and gender. *Sex* is the biological difference between males and females. For example, the fact that women can become pregnant and men cannot is a sex difference. *Gender* is a social construct that addresses

[28] It should be noted that the right to health is recognized in numerous international instruments which are binding on South Africa. These include the Convention on the Elimination of All Forms of Discrimination Against Women (which will be dealt with at a later stage), the Convention on the Rights of the Child and the African Charter on Human and People's Rights.
Article 24(1) of The Convention on the Rights of the Child provides: "States parties recognize the rights of the child to the enjoyment of the highest attainable standard of health."
Article 16 of the African Charter on Human and People's Rights provides: "Every individual shall have the right to enjoy the best attainable state of physical and mental health."

"personality traits, attitudes, feelings, values, behaviours, and activities that society ascribes to the two sexes on a differential basis."[29] For example, the work place discrimination that women face as a result of pregnancy is not a biological fact, but is a result of a social system of inequality that privileges men and subordinates women.

In the context of women's access to health care, factors relating to the low social standing of women in society is critical. The lower levels of education that many women have which ultimately results in higher levels of illiteracy among women, the working environment that many women find themselves in, the exceedingly high levels of violence against women all contribute to an overall pathetic state of women's health. These factors unequivocally result in women being more vulnerable to certain health risks. Furthermore, many health risks incurred by women are not incurred by men: for example, female genital mutilation, lesser attention to women's health in medical research, problems in reproductive health, lack of education for family planning, and special health risks for women at work.[30] It is accordingly vital that these factors are taken account of in the formulation of health policy.

It must be further acknowledged that "women have different body shapes, organ size and volume, and the distribution of fat. As a result, health problems need to be analyzed from the perspective of women because they suffer from:

- diseases or conditions that affect women and men differently;
- diseases or conditions unique to women or some groups of women;
- diseases or conditions that are more prevalent in women;
- diseases or conditions that are more serious among women or among some groups of women;
- diseases or conditions for which the risk factors are different for women or some groups of women;
- diseases or conditions for which the interventions are different for women or for some groups of women."[31]

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[29] Cook, Women's Health and Human Rights (WHO) (1994) at page 6.
[30] Leary, *The Right to Health in International Human Rights Law* (1) (1994) at page 17.
[31] Cook, Women's Health and Human Rights (WHO) (1994) at page 7.

In addition, whilst the White Paper should reflect a recognition of women's health, it should further take account of the reality that women in South Africa are clearly not a homogenous group, but rather divided along the lines of race, class, age, sexual orientation, marital status, geography (i.e. rural/urban) and ability. These groups of women face added barriers in gaining access to health care services which must be recognized and addressed. Whilst the added barriers that these groups of women face are dealt with in the context of reproductive health care, the White Paper should recognize that this clearly has implications for the overall state of health of these particular groups of women.

Furthermore, in order to adequately reflect a recognition of women's health issues, it is important that the White Paper accord due attention to the critical issue of violence against women. It should recognize the exceedingly high levels of violence against women in South Africa as well as the fact that violence against women is a major impediment to women's health. Domestic violence and rape are public health problems and are a significant cause of female morbidity and mortality. Hence, the White Paper should acknowledge that violence against women leads to psychological trauma, depression, substance abuse, injuries, sexually transmitted diseases and HIV infection, suicide and murder.[32]

Human Rights Watch, recently produced a report on violence against women in South Africa which indicated that the rates of violence against women in South Africa were the highest in the world. [33] The health impact of such violence cannot be underestimated. Violence both stems from and results in women's inability to choose when and whether to have sex; violence results in severe physical and psychological injuries; and violence interferes with women's abilities to be as productive and participatory in society as they deserve to be.

In the light of the high levels of violence against women in South Africa and its substantial impact on the health status of women, it is suggested that the White Paper pay special attention to both the issue of violence against women as well as its implications on the health status of women and

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[32] Global Commission on Women's Health, Women's Health: Towards a Better World, WHO, (1994), at page 25.
[33] Human Rights Watch, Violence Against Women in South Africa (1995) at page 3.

accordingly devote a specific chapter to addressing the dire health implications for women caused by violence against women.

Furthermore, the issue of women's health becomes especially pertinent in the context of the constitutional right to equality and the specific prohibition of discrimination on the grounds of gender, sex, race, pregnancy, marital status, ethnic or social origin, sexual orientation, colour, age, disability, religion, conscience, belief, culture, language, and birth. The prohibition of unfair discrimination clearly does not require the identical treatment of all individuals in all circumstances. In fact, it has been largely accepted that the equal and identical treatment of all individuals in a society of deeply entrenched inequalities can actually work so as to perpetuate such inequalities. It would accordingly follow that legislation and policy that appears neutral may have the effect of further entrenching persisting inequalities. This was acknowledged by the Constitutional Court in *President of the Republic of South Africa v Hugo*[34] where the court alluded to a substantive conception of equality which would require an analysis of the *actual circumstances* that a group of persons found themselves in.

In addition, the right to equality underlies all other rights in the Constitution and hence, the right to health must be understood in the context of the right to equality. Therefore, if the right to equality is substantively conceived, it would follow that the right of access to health care would similarly be subject to a substantive interpretation. A substantive interpretation of the right of access to health care would take account of the actual situation that the majority of women in South Africa find themselves in as regards access to health care services and require that there be measures in place to address these actual circumstances.

2.5.2. International Instruments and Women's Health:

In addition to the Constitution, international instruments reiterate the point that women's health must be taken into account in developing an understanding of the right to health. The role of international instruments in assisting in the interpretation of constitutional provisions is acknowledged in Section 39 of the Constitution, in terms of which international law *must* be considered in the interpretation of the rights in the Bill of Rights. Some attention will now be accorded to the most relevant international instruments.

The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW):

CEDAW aims first to ensure that gender does not impair women's ability to exercise their human rights and second, to dismantle the structures that perpetuate women's subordination in public and private life. It obliges States parties to undertake to prohibit and eliminate racial discrimination in the enjoyment of "the right to public health, medical care, social security and social services."[35]

It further obliges States Parties to take all appropriate measures to eliminate discrimination against women in the enjoyment of "the right to protection of health and to safety in working conditions, including the safeguarding of the function of reproduction."[36] It also provides that all appropriate measures should be taken by States Parties to eliminate discrimination against women "in the field of health care to ensure on a basis of equality of men and women, access to health care services, including those related to family planning."[37]

These provisions reiterate the fact that access to health care services must be provided on an equal basis and that women's health needs are reflected within the broader ambit of the right to health.

The Beijing Platform for Action:

On the subject of women's access to health care the Beijing Platform for Action notes as follows:

> "Women have the right to the enjoyment of the highest attainable standard of physical and mental health. The enjoyment of this right is vital to their life and well being and their ability to participate in all areas of public and private life. Health is a state of complete physical mental social well being and not merely the absence of disease or infirmity. Women's health involves their emotional, social and physical well being, and is determined by the social, political and economic context of their lives as well as by biology. However health and well being elude the majority of women. A major barrier for women to the achievement of the highest attainable standard of health is inequality, both between men and women and among women in different geographical regions, social classes, and indigenous ethnic groups. In national and international forums, women have emphasized that to attain optimal health throughout their life cycle,

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[34] Case CCT 11/96 (18 April 1997).
[35] Article 5(e)(iv), CEDAW.
[36] Article 11 (i)(f), CEDAW.

equality, including the sharing of family responsibilities, development and peace are necessary conditions."[38]

The Beijing Platform for Action reiterates that social inequality must be taken account of in developing health policy in order to ensure that access to health care is available to women as well as men. In view of the aforegoing, it is clear that both CEDAW and the Beijing Platform for Action lend support to the fact that women's access to health care services should form an integral and indispensable component of the right of access to health care services. In view of the constitutional right to equality, the reality of women's lives, the differences of the health needs of men and women as well as the aforementioned international instruments, it is recommended that women's access to health care is consistently reflected in the White Paper. Particular aspects as regards the subject will be commented on in the course of this submission. However, for the present purposes, it should be noted that an approach within which women's health issues are mainstreamed and consistently reflected throughout the policy is advocated as opposed to relegating the subject to a single chapter which tends to exclude women from the broader framework of access to health care services.

The World Health Organization Definition:

In adopting a definition of 'health care', the Department of Health should accord some attention to the definition of health as has been adopted by the World Health Organization which has noted as follows: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." [39]

In defining the term, *health care* which the South African Constitution provides for, as opposed to health *per se*, Prof. Ruth Roemer considers it to encompass "protective environmental services, prevention and health promotion and therapeutic services as well as related actions in sanitation, environmental engineering, housing and social welfare."[40]

[37] Article 12, CEDAW.
[38] Para 89, Beijing Platform for Action..
[39] The definition of health as adopted by the World Health Organization.
[40] Quoted in Leary, *The Right to Health in International Human Rights Law* (1) (1994) at page 4.

It is recommended that the White Paper on Health adopt a definition that reflects that of the World Health Organization and of Prof. Roemer which should reads as follows:

> "Health care consists of those measures that are necessary to ensure a state of complete physical, mental and social well-being that extends beyond the absence of disease or infirmity. It includes, but is not limited to protective environmental services, prevention and health promotion and therapeutic services as well as related actions in sanitation, environmental engineering, housing and social welfare."

It is considered important that the definition encompass a broad concept of health as well as make some specific reference to the types of measures that are required to ensure such a state of health. Furthermore, the definition would oblige the state both to promote health, social and related services and to prevent or remove barriers to the realization of physical, metal and social well-being. However, as international experience has proven that gender neutral definitions often perpetuate women's inequalities, it is important that the White Paper formulate certain specific strategies to specifically address women's health issues.

In the formulation of these strategies, the White Paper on Health should accord due recognition to the wide range of means that exist to protect various aspects of women's health in the international arena. These would include, but are not limited to:

- safeguards against coercive practices impairing women's freedom of choice regarding health care;
- elimination of spousal authorization practices, procedures for ensuring informed consent to health care;
- development of research protocols reflecting women's health needs and circumstances;
- regulation of health care delivery systems in order to ensure quality care;
- adoption and enforcement of safeguards against occupational health hazards;
- delivery of services, education and counseling to women in groups of high risks of maternal mortality or morbidity;
- delivery of a full spectrum of health care services including services in connection with reproductive and sexual health;
- measures to prevent and respond to violence against women in the family;
- adoption and enforcement of laws stipulating a minimum age for marriage;

- education to eliminate gender stereotyping and measures to ensure women's capacity to influence decision-making processes concerning health policy.[41]

In addition, a gender sensitive health policy would provide quality health care to women throughout their lives, not only during child bearing years and would provide appropriate services to all women across race, class, religion etc.

2.5.3. A Proposed Structure for the White Paper to Adequately Address Women's Health:
Whilst the White Paper's emphasis on health care services reaching women, which it considers to be among the most vulnerable groups is supported, specific strategies should be developed to ensure women's access to health care. Furthermore, as has been mentioned, women's health should be integrated throughout the White Paper. However, it is also recognized that in order to do justice in certain areas, these areas will need to be separated out and analyzed in a more comprehensive fashion.

It is recommended that reproductive health care, as *an aspect of women's health* should be accorded due recognition within a separate Chapter of the White Paper, which will be dealt with at a later stage. This section will deal with the biological sex differences between men and women as a result of women's reproductive capacity as well the gender implications on women's reproductive health. This particular structure is being suggested due to the common confusion between women's health and reproductive health. It must be stressed that reproductive health is only one aspect of women's health. Focusing solely on women as child bearers ignores women's full humanity.

Finally, in accordance with the earlier suggestion, it is recommended that the White Paper allocate a separate chapter to specifically address the impact of violence against women on the status of women's health generally, as well as specific strategies for addressing the issue.

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[41] Sullivan, *The Nature and Scope of Human Rights Obligations Concerning Women's Right to Health* Harvard Health and Human Rights Quarterly International Journal (1989) 1 at page 369.

3. Maternal, Child and Women's Health (Chapter 8):

The Department of Health's specific focus in the Chapter is commended. However, for reasons stated above, it is recommended that the Chapter focus only on maternal, reproductive and child health. As stated earlier, the right to health care in the Constitution explicitly includes the right to reproductive health care. In addition, the key international instruments in this area guarantee not only a right to health care, but specifically recognize the right to reproductive health care. Before examining the specific manifestations of the right to reproductive health care in the South African context, the actual meaning of the right to reproductive health care must be analyzed. Furthermore, the kind of obligations that the right of access to reproductive health care engenders on the part of the state as well as the minimum core content of the right will be considered. Finally, the necessary policy issues that the Department must confront in order to meet its obligations to ensure reproductive health care for all women in South Africa will be discussed.

3.1. Defining Reproductive Health:

Since Chapter 8 of the White Paper on Health fails to provide a comprehensive definition of the right of access to reproductive health care, it is suggested that some attention be accorded to the definition of the right. In view of the constitutional obligation to have regard for international law in the interpretation of the rights in the Bill of Rights, it is suggested that the Department of Health take account of the definitions of reproductive health care that have been provided in the relevant international instruments, which may prove useful in developing a definition for the purposes of the White Paper.

The Convention on the Elimination of All Forms of Discrimination Against Women:

CEDAW requires States parties to provide equal access to "educational information to help to ensure the health and well being of families including information and advice on family planning."[42] It prohibits discrimination in the field of health care ensuring equal access to health care services including family planning and requires states to:

[42] Article 10(h), CEDAW

"[E]nsure to women appropriate services in connection with pregnancy, confinement and post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation"[43]

The Convention on the Rights of the Child:

This Convention also guarantees a right to health. It concerns the right to health of persons under the age of 18 (or who have not attained majority). Specific measures include ensuring the health of children by requiring that states provide pregnant women with the health services necessary for safe delivery and by implicitly recognizing that adolescents also have specific reproductive health care needs.

The Programme of Action of the International Conference of Population and Development:

The Programme of Action of the International Conference of Population and Development: endorses a comprehensive concept of reproductive health which states:

"Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so."[44]

The World Health Organization (WHO):

The World Health Organization's definition is very similar to that of the ICPD except for the fact that WHO has identified a minimum level of reproductive health services. The issue of minimum core obligations as regards the right of access to reproductive health care will be dealt with at a later stage.

The Beijing Platform for Action:

The Beijing Platform for Action defines reproductive health as:

"A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity in all matters relating to the reproductive system and to its functions and processes.

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[43] Article 12, CEDAW, Quoted in Rahman and Pine, *An International Human Right to Reproductive Health Care: Toward Definition and Accountability* Harvard Health and Human Rights Journal (1989) 1 at page 405.

Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and to the freedom to decide if, when and how often to do so. Implicit in this last condition are the rights of men and women to be informed and to have access to safe effective affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law and the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. In line with the above definition of reproductive health, reproductive health care is defined as the constellation of methods, techniques and services that contribute to the reproductive health and well being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counseling and care related to reproduction and sexually transmitted diseases."[45]

In defining the term "reproductive health care," it is strongly recommended that the Department of Health adopt a comprehensive definition that adequately reflects the fact that reproductive health actually refers to the reproductive system of women in its entirety as opposed to limiting the term to maternal health care. It is accordingly suggested that specific attention is accorded to the definition of reproductive health as is provided for in the ICPD, the Beijing Platform for Action and the World Health Organization.

3.2. The Tripartite Obligations on the State as regards the Right of Access to Reproductive Health Care:

As has been mentioned, the state bears an obligation to respect, protect, promote and fulfill the right of access to reproductive health care. For example, the state's obligation to respect access to reproductive health care would require that it refrain from any coercive birth control practices or that it abandon a discriminatory state policy that, for instance may exclude women from the primary health care approach.

The state's obligation to protect the right of access to reproductive health care would require that the state protect women against violence which would result in negative consequences for their

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[44] Para 7.2. ICPD.

[45] Para 94, Beijing Platform for Action.

reproductive health status. A further example would be an obligation to protect the reproductive health care of women in private clinics which may be engaging in conduct that is harmful to women's reproductive health.

The obligation to promote and fulfill the right of access to reproductive health care would require that the state fulfill its minimum core obligations as regards access to reproductive health care. In an attempt to establish what the minimum core obligations on the state are in this regard, reference will once more be made to international instruments.

Once more, it is befitting to begin with a reference to the ICPD, which attempts to define the scope of reproductive health services. It defines reproductive health care as:

> "[T]he constellation of methods, techniques and services that contribute to reproductive health and well being by preventing and solving reproductive health problems. It also includes sexual health."

It contributes to a discussion of the content of reproductive health care by attempting to delineate the types of health care services that 'should' be provided. These reproductive health care services *may be* considered to be the core minimum in terms of the ICPD Programme which provides:

> "Reproductive health care in the context of primary health care should inter alia include: family -planning counselling, information, education, communication and services; education and services for prenatal care, safe delivery care, and post natal care, especially breast-feeding and infant and women's health care; prevention and appropriate treatment of infertility; abortion as specified in Para 8.25, including prevention of abortion and management of the consequence of abortion; treatment of reproductive tract infections, sexually transmitted diseases and other reproductive health conditions; and information, education and counselling as appropriate, on human sexuality, reproductive health and responsible parenthood."[46]

As has been mentioned, The World Health Organization's definition is very similar to that of the ICPD except for the fact that WHO has specifically identified a minimum level of reproductive health services as follows:

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[46] Rahman and Pine, *An International Human Right to Reproductive Health Care: Toward Definition and Accountability* Harvard Health and Human Rights Quarterly International Journal (1989) I at page 407.

> "A reproductive health package must include as a minimum components of family planning, STD prevention and management and safe motherhood. A cluster of interventions for safe motherhood must be at the centre of any reproductive health strategy."[47]

In the development of minimum core standards as regards reproductive health care, it is suggested that the Department of Health have due regard to the minimum core standards that have been developed by the Beijing Platform for Action. This definition is preferable because it is broad enough to encompass the full spectrum of women's reproductive health needs.

3.3. Reproductive Health Care and Needs Among Particular Groups of Women:

In addition to the recommendation that the White Paper provide for a comprehensive definition of reproductive health care, it is suggested that it accord specific attention to the reproductive health care needs among particular groups of women. As has been mentioned, this would take account of the reality that women in South Africa are clearly not an homogenous group but, rather divided along the lines of urban/rural, rich/poor, age, sexual orientation, marital status, race and ability. In taking account of the reproductive health rights of particular groups of women, the Department of Health is urged to accord due regard to the following categories of women.

Rural Women:

Whilst this submission has sought to emphasize the needs of all women in South Africa, the needs of rural women in the context of access to health care, including reproductive health care are particularly pressing. Whilst the focus on this vulnerable group by the White Paper is commendable, it is strongly recommended that it provide for certain specific measures that adequately reflect the health needs of rural women.

Support for this contention is evident in CEDAW which makes special reference to rural women and obliges states to ensure aspects of the underlying rights to health and health care *beyond* those associated with reproductive health. It expressly guarantees rural women a right of "access to *adequate health care facilities*, including information, counseling and services in family

[47] *ibid* at page 409.

planning."[48] The possibility of a similar provision should be considered for the purposes of the White Paper.

Poor Women:

Poor women in South Africa have more pressing health care concerns than middle class or rich women. Among certain diseases such as tuberculosis and leprosy, recent studies indicate that while women may not be infected more than men by these diseases, they often tend to suffer more serious consequences. This may be due in part to the fact that women ignore their symptoms until they are extremely severe or because of guilt that their illness prevents them from acting in their care taking role.[49] Poor women also often ignore their symptoms due to the excessive financial burden of accessing health care services. For example, the many hidden health care costs such as public transport, loss of working hours and the actual cost of the health service itself, may discourage many poor women from seeking health care services.

The Girl-Child

It is beyond the scope of this paper to address the specific health needs of girl children. We refer the Portfolio Committee to submissions on children's health more generally for this information. However, the White Paper should acknowledge that childhood sexual abuse can negatively impact on reproductive health organs of girls and women. Furthermore, with the increasing prevalence of HIV and AIDS, young girls are increasingly being sexually exploited through prostitution because they are seen as "safer targets." Clearly, this demands that the specific reproductive health needs of the girl child within this particular context are taken account of. It should be noted that South Africa has ratified the Convention on the Rights of The Child which notes the health needs of the girl child.

Adolescents:

The ICPD[50] and the Beijing Platform for Action[51] also urge governments to address adolescent sexuality through educational programmes in sexual and reproductive health that are made available to and understandable by the young and through the provision of contraceptive

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[48] Article 14 (2) (b), CEDAW.
[49] Cook, Women's Health and Human Rights (1994) (WHO) at page 12.
[50] ICPD, para 7.47.

Refugee and Migrant Women:

Being uprooted from one's home is a stressful experience which results in them facing economic, social and psychological difficulties. Groups of refugees and migrants are often exposed to physical danger, psychological trauma and exploitation which negatively impacts on the health of refugee and migrant women. The White Paper should accordingly address the social and psychological issues affecting refugee and migrant women which adversely impacts on their health.

Lesbians:

Lesbians often find that their experience regarding health care differs from those women who have relationships with men. For instance, because lesbians fear the prejudice of health workers, they either stay away from health care workers or avoid disclosing relevant information about their sexual orientation. This ultimately means that they do not get the health care they need. Furthermore, because lesbians are less likely to have children, they are at greater risk of developing cancer of the breast, ovaries and lining of the womb. In addition, lesbians do not have access to pap smears within the public sector as these are available only to women who visit family planning clinics or ante natal clinics. As lesbians do not need contraception and do not often become pregnant, they are denied this form of testing for cancer.[54]

3.4. Specific Ailments, Procedures and Harmful Practices Relevant to Reproductive Health Care:

Reproductive Tract Infections(RTI's):

RTI's are a frequent problem for poor women which often go undiagnosed and untreated. There are numerous causative factors outlining RTI's some of which are biological but most of which are due to gender discrimination. All RTI's are preventable and most are curable, yet they do not receive the priority they deserve. Because of the power relations inherent in heterosexual relationships, women are in many instances unable to negotiate condom use with their partners. This results in high rates of RTI's. Social factors which contribute to the spread of RTI's and STD's include the increase in commercial sex work, the shame and secrecy surrounding RTI's and STD's and consequently the low priority given to their prevention and treatment in terms of resource allocation. Furthermore, diagnosis is not easy and treatment can be expensive. The consequences of RTI's are serious and include: post partum or post abortion sepsis, pelvic

inflammatory disease, ectopic pregnancy, cervical cancer, fetal and prenatal death, infertility with the accompanying social rejection and emotional stress. RTI's are asymptomatic or are perceived as being natural or minor. However, chronic low grade reproductive tract infections greatly increase women's susceptibility to more serious infections including HIV/AIDS. Matters are further complicated by the non availability of treatment for RTI's as part of the mother and child health or family planning services. It is in this light that it is strongly recommended that the White Paper take account of the seriousness of RTI's and the negative impact they have on women's reproductive health.

Sexual Transmitted Diseases (STD's):

The Department of Health's commitment to improving the quality of STD services in both the public and private sectors is welcomed.[55] As STD's have a profound impact on women's reproductive health, it is recommended that they be addressed in the Chapter on Reproductive, maternal and child health. STD's are five times more likely to occur in women than in men and are responsible for the second highest burden of disease in developing countries. Women's susceptibility to STD's is based both on biological and social realities. Women's reproductive systems expose a greater surface area of sensitive tissues to a greater variety of pathogens during intercourse. When delicate mucosal tissue is torn or damaged, the risk of the transmission of STD's, including HIV/AIDS is greatly increased. In addition, sexual practices (including a preference for "dry sex" which increases friction and male sexual pleasure), can increase the likelihood of injury to women. STD's can cause pregnancy related complications, sepsis, spontaneous abortions, premature birth, still birth and congenital infections. They can further increase the risk of cervical cancer, as well as reproductive tract disorders. Finally, an STD can increase the chance that any single sexual encounter will transmit the HIV virus. Research has shown that adolescent women are the group facing the highest rate of STD's and are at greater risk than other groups of women and men.[56]

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[54] Goosen and Klugman (eds.) <u>The South African Women's Health Book</u> (1996) at page 484.
[55] White Paper on Health 9.1.1 (c) (iii)
[56] Ravindran, <u>Gender Issues in Health Projects and Programmes</u> (Report from the AGRA East Meeting, 15-19 November 1993, The Philippines)

The impact of STD's is particularly severe in women as symptoms often go undetected until quite late. This is due in part to the stigma attached to women with STD's and the resulting poor treatment they often receive from health care workers makes them reluctance to seek health care. In view of the aforementioned issues, it is suggested that STD's are addressed in a more comprehensive way in the context of reproductive health.

Female Genital Mutilation:

Female genital mutilation (also incorrectly referred to as female circumcision) according to the WHO definition, comprises all procedures involving partial or total removal of the external female genitalia or other injury to female genital organs. While its prevalence in the South African context is as yet unknown, the White Paper should acknowledge that this practice violates the right to freedom and security of the person, equality, human dignity, potentially the right to life, in addition to posing serious risks to the reproductive health of the individual. For example, the practice can increase the likelihood of recurrent genital tract infections and other disorders which increase the risk of STD infections. This would also be in line with the South African Government's commitment to enforce the prohibition of female genital mutilation in terms of the ICPD[57] and the Beijing Platform for Action.[58] This commitment is reiterated in CEDAW.[59]

Termination of Pregnancy

We commend the Health Department and the Portfolio Committee on Health for the passage of the Choice on Termination of Pregnancy legislation, and the availability of safe access to abortion for women in South Africa. However, we urge that the White Paper ensure that specific monitoring procedures are in place to ensure that all women, especially rural women have access to termination of pregnancy services.

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[57] Para 4.22, 5.5 and 7.41, ICPD.

[58] Para 124 (i) and 283 (d).

[59] Article 5 (a) of CEDAW obliges States "to modify the social and cultural patterns of conduct of men and women, with a view to achieving the elimination of prejudices and customary and all other practices which are based on the idea of the inferiority or superiority of either of the sexes or on stereotyped roles for men and women.

Cervical Cancer:

The White Paper's undertaking that pap smears will be conducted at scheduled intervals and provision will be made for appropriate management where required is supported.[60] The importance of this provision is reaffirmed by the fact that research has indicated that cervical cancer is the leading cause of death from cancer among black women in South Africa.

Breast Cancer:

The White Paper's undertaking that breast examinations will be conducted at scheduled intervals and provision will be made for appropriate management where required is supported.[61] Breast cancer is the leading cause of cancer death among women in most developed countries and many developing countries. There has been an increase by 22% in breast cancer mortality over the past 2 decades. Early detection is accordingly vital. While the combination of examination by a physician and regular mammograms have proven most effective, South African women would greatly benefit from learning the techniques of self-examination from health care workers. Breast self examination is simple, inexpensive, non invasive and non hazardous. It is accordingly suggested that the White Paper undertake to educate women on the techniques of self-examination for breast cancer. Furthermore, it is recommended that more intensive screening programmes be adopted for women in high risk groups.[62]

4. Primary Health Care (PHC) (Chapter 2):

The Primary Health Care(PHC) approach as adopted by the White Paper on Health is supported. However, it is suggested that a comprehensive definition of primary health care be provided for in the White Paper. It is further recommended that primary health care is addressed in a manner that takes account of women's health and reproductive health care.

As regards the definition, it is suggested that primary health care be defined as:

> "Essential health care based on practical, scientifically sound and socially acceptable methods and technology, made universally acceptable to individuals and families in the community through their full participation, and at a cost that the community and country can afford to

[60] White Paper on Health, paragraph 8.6.1 (d)

[61] *ibid*

maintain at every stage of their development in the spirit of self reliance and self determination."[63]

The three main principles underlying the primary health care concept are as follows:

- First, that health is an integral part of development.
- Second, the need is not so much to make further advances in medical technology as to re-orientate the health system to make existing technology available to all.
- Finally, the primary health care approach maintains that the conscious participation of people in the care for their own health is fundamental to the achievement of good health.[64]

In line with these principles, the PHC approach advocates a move from hospital based care toward prevention of ill health, making health services available at the community level and emphasizing what people can do for themselves to improve their health.[65]

While primary health care is an important policy in order to alleviate the gross inequities in the health care system, equally important should be that primary health care alleviate the current gender bias in health care as well as other biases such as racial, class, rural-urban etc. A gender sensitive primary health care approach must take into account the ways in which the sexual division of labour, and gender based discrimination influence women's health status. A gender sensitive approach to primary health care must also view women as holistic human beings, rather than merely as mothers or wives. It should further take account of the multiplicity of roles that women in South Africa perform and the deleterious effects on their health.

According to Ravindran, addressing gender in a primary health care approach would mean:

- acknowledging and acting on the premise that the community is not a homogenous group but may be divided along lines of gender, class, race, ethnicity and caste;
- being aware of how gender roles affect women's health needs and the variations in these across different social stratums;

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[62] Smyre, Women and Health (1993) at page 95.
[63] Ravindran, Gender Issues in Health Projects and Programmes (Report from the AGRA East Meeting, 15-19 November 1993, The Philippines)
[64] *ibid*
[65] *ibid*

- addressing problems faced by women as providers of health care within the formal health sectors and as informal carers at home;
- recognizing, valuing, and using women's indigenous knowledge and skills in traditional medicine;
- changing the tendency in health education to 'blame the victim';
- planning in consultation with women and respecting women's knowledge of the community's health needs.[66]

In addition, it is recommended that the primary health care system include comprehensive reproductive health care, throughout a woman's life span and not only during child bearing years. As has been stressed, a gender sensitive primary health care system must focus on reproductive health care that recognizes that reproductive health care is more than about reproduction.

5. Financial and Physical Resources (Chapter 3):

This chapter is beyond the scope of this submission

6. Developing Human Resources for Health (Chapter 4):

The Department of Health is commended for their specific acknowledgement of the need for developing human resources for health. However, it is contended that whilst training for practice in a health care profession is critical, equally critical is training that helps health care workers to be gender, race, and culturally sensitive in their practices. It is important that stereotypes about women and their health needs are addressed during such training. For example, such training might include information about women with disabilities and their abilities to engage in sexual activity; information about the myths of domestic violence (trivializing the health affects of domestic violence), information about lesbians and their reproductive health needs and information about the impact of sexual assault on women's physical and psychological health. Health care workers must also be given information and training about the distinct physiological, psychological, and social features of women's health, to ensure that they treat women with appropriate regard for their circumstances.

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[66] Ravindran, Gender Issues in Health Projects and Programmes (Report from the AGRA East Meeting, 15-19 November 1993, The Philippines)

diseases, and that women suffer from certain diseases which men do not suffer from. It is essential that all health research takes account of the physiological differences between men and women, as well as the lifestyle differences which result from gender inequality. In addition, it is critical that adequate research is undertaken in areas of health that specifically impact women, for example reproductive health and cancers of the female organs. Also important in developing research priorities is taking account of the differential impact that certain diseases have on different groups of women. For example, cervical cancer affects poor women and should therefore be a research priority.

8. Health Information (Chapter 6):

In an attempt to ensure that women are in a position to make informed decisions regarding their health status, as well as to provide informed consent, with regard to proposed treatment, it is essential that they gain access to the necessary health information. As has been noted previously, the Constitution itself recognizes the right of access to information which is necessary for the exercise or protection of any fundamental rights. Hence, the right of access to information is critical in ensuring access to health care services.

As has already been pointed out, it is equally important that information takes account the diversity of women in South Africa and that information is culturally and linguistically appropriate across a range of literacy levels. It is accordingly recommended that the White Paper on Health make specific provision for such information to be modified to meet the needs of its particular target group. Access to information provides a prime area for intersectoral collaboration, for example, with the Department of Education. In this regard, sexuality and health and reproductive education must be an integral component of the school curriculum.

9. Nutrition (Chapter 7):

While adequate nutritional intake is important for everyone, and closely linked to patterns of morbidity and mortality, it is particularly important for girls and women. This is due to intergenerational and cumulative effects which permeate different phases of a women's life. For instance, protein-energy, malnutrition, and micronutrient deficiency's at various stages of life contribute to morbidity and mortality from a variety of infections and chronic diseases. Given the

[69] Cook, Women's Health and Human Rights (1994) at page 40.

social context of institutionalized subordination based on gender, nutrition as regards the girl child and women should be of particular concern to the Department of Health and accordingly reflected in the White Paper on Health.[70]

10. Chapter 8: Maternal Child and Women's Health:

As has been noted, it is recommended that this chapter focus solely on maternal, reproductive and child health and that women's health be incorporated throughout the White Paper.

11. HIV/AIDS and Sexually Transmitted Diseases (Chapter 9):

> *"By the year 2000 over 14 million women will have been infected and 4 million will have died. Women world wide are asking why a virus that infects both men and women is increasingly infecting women in a disproportionate way. The bleak reality is that sexual and economic subordination of women fuels the HIV/AIDS pandemic. In order to break this cycle of neglect, it is essential to undertake actions which allow women to make informed choices and enable them to improve the quality of their lives... social vulnerability cannot be challenged by women alone... building effective alliances ... remains the greatest challenge, but also the best hope for tomorrow.*[71]

The Department of Health is commended on their attention to the specific impact of HIV and AIDS on women. However, it is recommended that the White Paper be even more thorough in its gender analysis of HIV/AIDS. In order to address the AIDS epidemic, the multiple roles of women as well as the impact of women's subordination must be taken into account in every facet of health planning and policy.

HIV/AIDS impacts on everybody but it is poor, rural, and peri-urban women who bear the brunt of the infection.[72] It is clear that women are often unable to negotiate whether or not to have sexual intercourse or whether or not a condom will be worn. Subordination of women results in them

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[70] Global Commission on Women's Health, Women's Health: Towards a Better World (1994) (WHO) at page 15.

[71] Quoted in Jacobs, *HIV and AIDS: A Gender Perspective in Public Health* (1998) (Unpublished) at page 3.

[72] Budlender (eds.) The Second Women's Budget (1997) Idasa at 298

often being economically dependent on their male partners such that they may be faced with "divorce or dire poverty on the one hand and the risk of the HIV infection" on the other. The choice becomes one of social death or biological death.[73]

In addition, women appear to be more vulnerable biologically to the HIV virus. Transmission of HIV from men to women is as much as two to ten times more efficient than from women to men.[74] Women's susceptibility to STD's and RTI's as has been noted, further contributes to their susceptibility to the HIV virus.[75]

Commercial sex workers have taken the brunt of considerable accusation and blame for the spread of AIDS.[76] This blame obscures the reality that women in commercial sex work are often unable to negotiate condom use in whatever sexual activities they engage in and that they are often subject to severe levels of violence.

In addition, it is women who bear the burden of caring for men and women who suffer through the epidemic as well as taking care of the children whose caretakers are no longer able to take care of them. [77] It is important that this large social and economic issue be factored into the White Paper on Health.

12. Communicable Diseases (Chapter 10):

This chapter is beyond the scope of this submission.

13. Environmental Health (Chapter 11):

The Department of Health is commended for accepting the World Health Organization's Global Strategy for environment and health. We further endorse the focus on rural inequalities in socio economic development. However, it is also recommended that the approach be disaggregated by gender.

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[73] Jacobs, *HIV and AIDS: A Gender Perspective in Public Health* (1998) (Unpublished) at page 7.
[74] Goosen and Klugman, The South African Women's Health Book. (1996) at page 24
[75] *ibid.*
[76] Jacobs, *HIV and AIDS: A Gender Perspective in Public Health* (1998) (Unpublished) at page 4.
[77] Budlender (eds.) The Second Women's Budget (1997) Idasa at 298.

14. Mental Health and Substance Abuse (Chapter 12):

The acknowledgement in the White Paper of the specific impact of violence against women on their mental health status is supported.[78] However, it is further suggested that the mental health consequences of gender inequality on women is acknowledged and accorded due attention. Furthermore, it is recommended that the correlation between substance abuse and sexual violence is recognized and addressed so that appropriate gender sensitive treatment programmes can be developed. Finally, it is suggested that the mental health needs of particular groups of women be taken into account. For example, the discrimination that women with disabilities and lesbians face may result in adverse mental health consequences, which must be recognized and addressed in an appropriate way.

15. Oral Health (Chapter 13):

This chapter is beyond the scope of this submission

16. Occupational Health (Chapter 14):

Work performed in the home frequently misrepresented as unemployment presents no fewer hazards to health than industrial employment. Work in the home may require malnourished women to toil for long hours in carrying heavy burdens, in preparing food over stoves heated by smoke generated fuels in unventilated spaces, and in domestic agriculture. Exposure to heating fuels and household chemicals will often be significantly greater among women than among men. Injuries from accidents in the home including burning and scalding are often as frequent as injuries in the workplace. Skeleton damage from carrying heavy weights including fetching water is more common among women than among men in certain parts of the world.

Women competing for employment with may be at a greater risk of harm from heavy toil and physical hazards and women in employment that is typically feminine are liable to suffer low pay and long hours. Women in employment outside the home frequently bear a double burden, in that after earning a hard days pay, they are responsible for all the domestic work in their homes. This aggravates the health strains that affect them and its time for self care and recuperation.[79]

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[78] Para 12.2.1.(a), White Paper on Health.

[79] Cook, Women's Health and Human Rights (1994) (WHO) at page 10.

17. Academic Health Service Complexes (Chapter 15):

This chapter is beyond the scope of this submission.

18. National Health Laboratory Services (Chapter 16):

This chapter is beyond the scope of this submission.

19. The Role of Hospitals (Chapter 17):

This chapter is beyond the scope of this submission.

20. Health Promotion and Communication (Chapter 18):

The Department of Health is commended on their comprehensive and progressive strategies for health promotion. However, we wish to stress that decisionmaking processes for campaigns must be transparent, well communicated, and a reflection of women's needs in a gender sensitive manner. All Campaigns must aim at providing accurate information that is critical to the well being of women's health. It is also important that such campaigns do not reaffirm stereotypical images of women. For example, the campaign on sexual assault relied on rape myths rather than empowering women to know their rights. Also, the recent campaign, "a handbag of women's health rights" relies on gender stereotyping to promote women's health. While we support Campaigns specifically targeting women and women's health needs, it is important the Department not fall into the trap of dangerous gender role stereotyping.

21. The Role of Donor Agencies and Non-Governmental Organizations (Chapter 19):

This chapter is beyond the scope of this submission.

22. International Health (Chapter 20):

We endorse the principles of cooperation that the Department of Health intends establishing with the international community. However, international law pertaining to health rights has consistently been incorporated throughout this submission and hence does not warrant specific attention in this chapter. In this regard, we urge the Department of Health to incorporate specific international provisions relevant to health into the White Paper.

23. Year 2000 Health Goals, objectives and indicators for South Africa (Chapter 21):

We commend the Department of Health for its specific health goals, objectives and indicators as regards health care. However, it must be stressed that in the development of indicators, factors related to women's health and reproductive health must be specifically accounted for. The Department of Health is further urged to engage in a process of constant review of these goals and undertake modification and amendment where necessary.

24. Conclusion:

Once more, we wish to thank the Portfolio Committee on Health for the transparent and consultative way in which the White Paper on Health has been developed. The transformation of the South African Health Care system from its fragmented and discriminatory past to a system premised on democracy, equality and consultation is heralded. However, whilst the vital role of policy and legislation cannot be underestimated, the Department of Health is urged to ensure its proper implementation. In this way, access to quality health care for all South Africans will one day become a reality.