The right to have access to health care services for survivors of gender-based violence

Tarryn Bannister

14639009

Thesis presented in fulfilment of the requirements for the degree of Master of Laws at Stellenbosch University

University Supervisor: Prof S Liebenberg

December 2012

Declaration

By submitting this thesis/dissertation electronically, I declare that the entirety of the work contained therein is my own, original work, that I am the sole author thereof (save to the extent explicitly otherwise stated), that reproduction and publication thereof by Stellenbosch University will not infringe any third party rights and that I have not previously in its entirety or in part submitted it for obtaining any qualification.

Summary

In South Africa gender-based violence (hereafter "GBV") has reached extreme levels. This violent manifestation of gender inequality is compounded by the fact that women are disproportionately affected by poverty, the HIV/AIDS epidemic and inadequate health care services. This is in spite of South Africa's progressive constitutional and legislative framework which appears highly conducive to combating gender inequality and GBV. For example, the Constitution protects the right to equality (section 9), human dignity (section 10), life (section 11), freedom and security of the person (section 12) and the right to have access to health care services, including reproductive health (section 27(1)(a)). Extensive legislation has also been enacted for the protection of women. For example, the preamble to the Domestic Violence Act 116 of 1998 (hereafter "DVA") recognises domestic violence as a serious social evil. While the DVA is notably silent as to the role of the health care sector, the DVA is progressive in that it contains a broad definition of domestic violence, and recognises a wide range of relationships. The Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007 also seeks to afford complainants of sexual offences "the maximum and least traumatising protection that the law can provide". In addition to this, South Africa has international law obligations to address GBV and gender inequality. For example, under the Convention on the Elimination of All Forms of Discrimination against Women (1979), States are obliged to address private acts of violence and to remove discrimination against women in all fields, including health. However, despite this progressive framework of rights, some interpretations of these integral rights have been unduly formalistic, in addition to being disengaged from the lived reality of many women. There is also a substantial gap between policy and practice, with the implementation of existing legislation a continuing problem. It is therefore imperative that we analyse the right to have access to health care services through a gender lens so as to transcend a purely legalistic perspective and to interrogate gendered social processes and power relations. This thesis analyses how existing law and policy can be transformed so as to be more responsive to these lived realities and needs of survivors of GBV.

Opsomming

Geslagsgebaseerde geweld (hierna 'GGG') in Suid-Afrika het uiterste vlakke bereik. Hierdie gewelddadige manifestasie van geslagsongelykheid word vererger deur die feit dat vroue buite verhouding erg deur armoede, die MIV/vigs-epidemie en ontoereikende gesondheidsorgdienste geraak word. Dit is ondanks Suid-Afrika se vooruitstrewende grondwetlike en wetsraamwerk wat op die oog af hoogs bevorderlik vir die bestryding van geslagsongelykheid en GGG voorkom. Die Grondwet verskans, byvoorbeeld, die reg op gelykheid (artikel 9), menswaardigheid (artikel 10), lewe (artikel 11), vryheid en sekerheid van die persoon (artikel 12) en toegang tot gesondheidsorgdienste, met inbegrip van reproduktiewe gesondheidsorg (artikel 27(1)(a)). Omvattende wetgewing oor vrouebeskerming is ook reeds uitgevaardig. Die aanhef tot die Wet op Gesinsgeweld 116 van 1998 (hierna die 'WGG') identifiseer, byvoorbeeld, huishoudelike geweld as 'n ernstige maatskaplike euwel. Hoewel die WGG swyg oor die rol van die gesondheidsorgsektor, is dit nietemin vooruitstrewend aangesien dit 'n uitgebreide omskrywing van huishoudelike geweld bevat en 'n wye verskeidenheid verhoudings erken. Die Wysigingswet op die Strafreg (Seksuele Misdrywe en Verwante Aangeleenthede) 32 van 2007 is ook daarop afgestem om klaagsters van seksuele oortredings "die omvattendste en mins traumatiese beskerming te gee wat die wet kan bied". Daarbenewens verkeer Suid-Afrika onder internasionale regsverpligtinge om GGG en geslagsongelykheid aan te spreek. Ingevolge die Konvensie vir die Uitwissing van Alle Vorme van Diskriminasie teen Vroue (1979), byvoorbeeld, is state verplig om privaat geweldsdade teen te staan en diskriminasie teen vroue op alle gebiede te verwyder, insluitend gesondheid. Nietemin, benewens hierdie vooruitstrewende menseregteraamwerk is sommige interpretasies van hierdie onafskeidbare regte nie net oormatig formalisties nie, maar ook verwyderd van die daaglikse realiteit van baie vroue. Daar is ook 'n wesenlike gaping tussen beleidsmaatreëls en die praktyk, terwyl die uitvoering van bestaande wetgewing 'n voortgesette probleem verteenwoordig. Dit is dus gebiedend om die reg op toegang tot gesondheidsorgdienste deur 'n geslagslens te analiseer om sodoende 'n bloot regsgedrewe perspektief te bo te gaan en om

maatskaplike prosesse en magsverhoudinge in oënskou te neem. Hierdie tesis analiseer hoe bestaande wetsraamwerke en beleidsmaatreëls getransformeer kan word om beter te reageer op die realiteite en behoeftes van oorlewendes van GGG.

Acknowledgements

First and foremost, thank you to the Hope Project, and to the Bradlow Foundation for providing me with the financial support to complete my studies. I am deeply grateful for the opportunity to further my studies and particularly for the opportunity to pursue an LLM degree within the area of law that I am most passionate about.

Most importantly, thank you to my promoter, Professor Sandra Liebenberg, for your enduring patience, support and guidance throughout this entire process. You have been a great inspiration and a wonderful mentor.

Thank you to my friends, particularly Margot Strauss and Gareth Truebody, for reading earlier drafts of this thesis and for providing me with your patient critiques.

And finally, thank you to my family, for all of your support during the past two years. I couldn't have done it without you all.

Table of Contents

Table of Abbreviations:

CEDAW	Convention on the Elimination of all forms of Discrimination against Women
CVAW	Consortium on Violence against Women
DEVAW	Declaration on the Elimination of Violence against Women
DVA	Domestic Violence Act 116 of 1998
GBV	Gender-based violence
GDP	Gross domestic product
ICESCR	International Covenant on Economic, Social and Cultural Rights
ICCPR	International Covenant on Civil and Political Rights
NHA	National Health Act
NHI	National Health Insurance
OAS	Organisation of American States
PEP	Post-exposure prophylaxis
SALRC	South African Law Reform Commission
SGBV	Survivors of gender-based violence
SOA	Criminal Law (Sexual Offence and Related Matters) Amendment Act 32 of 2007
TLAC	Tshwaranang Legal Advocacy Centre
UDHR	Universal Declaration of Human Rights
UNESCR	United Nations Committee on Economic, Social and Cultural Rights

1 Introduction

1 1 Background to the research problem: Gender-based violence in South Africa

Gender-based violence (hereafter "GBV") has been described as the most widespread and socially tolerated of human rights violations.[1] Combating this epidemic has thus been identified by some as the leading moral and human rights issue of this century with the statement that:

> "The global statistics on the abuse of girls are numbing. It appears that more girls have been killed in the last fifty years, precisely because they were girls, than men were killed in all the battles of the twentieth century. More girls are killed in this routine 'gendercide' in any one decade than people were slaughtered in all the genocides of the twentieth century."[2]

In relation to South Africa, GBV has reached extreme levels. For example, in Gauteng alone, a woman is killed every six days.[3] In 1996, research revealed that in South Africa a woman is murdered every six hours by her intimate partner.[4] A 2009 report further stated that one in four women experience violence within their lifetime.[5] Rape has also become an epidemic within South Africa. According to crime statistics for the year of 2011 66,196 rapes were reported to the South African Police Services.[6] This is an

[1] United Nations Population Fund "Gender-Based Violence: A Price Too High" in *State of the World Population 2005: The Promise of Equality: Gender Equity, Reproductive Health and the Millennium Development Goals* (2005) 65 65 <http://www.unfpa.org/swp/2005/index.htm> (accessed 24-02-2011).
[2] N Kristof & S Wudunn *Half the Sky: How to Change the World* (2010) xviii.
[3] L Vetten "Man Shoots Wife: Intimate Femicide in Gauteng in South Africa" (1996) 6 Crime and Conflict 1 1 < http://www.csvr.org.za/wits/papers/papvet1.htm > (accessed 14-01-2011).
[4] S Mathews, N Abrahams, LJ Martin, L Vetten, L Van der Merwe & R Jewkes "Every Six Hours a Woman is Killed by her Intimate Partner" (2004) 5 *Medical Research Council Policy Brief* 1 1 <http://www.mrc.ac.za/policybriefs/woman.pdf> (accessed 15-02-2011).
[5] U Lau "Intimate Partner Violence Fact Sheet*",* (2009) Medical Research Council Crime, Violence & Injury (Lead programme) 1 1 <http://www.mrc.ac.za/crime/intimatepartner.pdf> (accessed 05-02-2011).
[6] South African Police Services: Crime Research and Statistics Information Management "Total Sexual Offences in the RSA for April to March 2003/2004 to 2010/2011" <http://www.saps.gov.za/statistics/reports/crimestats/2011/categories/total_sexual_offences.pdf> (accessed 04-05-2012).

alarming number, as rape is a notoriously underreported crime.[7] There are other forms of GBV, such as sexual harassment, stalking,[8] corrective rapes, human trafficking,[9] female genital mutilation and witch hunts, for which there are currently no reliable statistics. This has rendered these crimes 'invisible' within our society. Existing statistics on GBV therefore only represent the tip of the iceberg. The underreporting of GBV is partly due to the unique nature of this violence which essentially evokes a feeling of shame and self-blame in those who are attacked.[10] However, one cannot ignore the role of the State in compounding this shame by failing to adequately recognise and address all forms of GBV.[11] Given the extreme levels of such violence, there is clearly a need for a greater recognition and response to all forms of GBV.

1 2 Gender-based violence as a public health concern

GBV is both a public health concern and a human rights issue with devastating health consequences. Fatal health outcomes include AIDS- related mortality, maternal mortality, homicide and even suicide.[12] Non-fatal consequences include bone fractures, haemorrhaging, disability, gastrointestinal problems, central nervous system disorders,

[7] S Roehrs "Half-hearted HIV Related Services for Victims" in L Artz & D Smythe (eds) *Should We Consent?: Rape Law reform in South Africa* (2008) 175 175.

[8] There is currently a Protection from Harassment Bill 1 of 2010 which has yet to be enacted. The Bill is available online at: < http://us-cdn.creamermedia.co.za/assets/articles/attachments/25700_100208b1-10.pdf> (accessed 16-04-2011).

[9] According to the United States Department of State, an estimated 800,000 men, women and children are trafficked internationally each year, with women and children making up 80 per cent of this estimate. See: United States Department of State "Trafficking in Persons Report" (2005) 1 7 <http://www.state.gov/documents/organization/47255.pdf> (accessed 25-03-2011). Despite its high prevalence, South Arica currently lacks a legislative framework on human trafficking. For example, sections 70-71 of the Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007 are only transitional provisions relating to the trafficking of adults and children for sexual purposes only. Furthermore, while there is currently a Prevention and Combating of Trafficking in Persons Bill 7 of 2010, this Bill has yet to be enacted and fails to adequately provide for the health care needs of survivors of human trafficking.

[10] M Nussbaum "Women's Bodies: Violence, Security Capabilities" (2005) 6 *Journal of Human Development* 167 169.

[11] L du Toit "A Phenomenology of Rape: Forging a New Vocabulary for Action" in A Gouws (ed) *(Un)thinking Citizenship: Feminist Debates in Contemporary South Africa* (2005) 253 254.

[12] L Heise & C Garcia-Moreno (World Health Organisation) "Violence by Intimate Partners" in G Etienne, L Krug ,J Dahlberg, AM Anthony, B Zwi & R Lozano (eds) *World Report on Violence and Health* (2002) 87 100 <http://whqlibdoc.who.int/publications/2002/9241545615_chap4_eng.pdf> (accessed 13-02-2011).

chronic pain, sexual and reproductive health problems and mental illness.[13] In relation to reproductive health, GBV can result in HIV/AIDS infection, unwanted pregnancy, induced abortion and sexually transmitted infections and diseases.[14] Psychologically, GBV can result in severe depression, often rendering complainants unable to carry out daily tasks. GBV can also lead to sleep disorders, anxiety, post-traumatic stress disorder and attempted suicide.[15] GBV can further result in self-destructive behaviour, such as drug abuse and sexual risk-taking. The effects of gender inequality and GBV can also be subtle and subversive. For example, women in abusive relationships may be unable to allocate household resources to necessary health care services due to the gendered power imbalances within their relationship.[16] Abused women may further be unable to negotiate condom usage[17] or the number and spacing of their children, with reproductive health implications. Furthermore, research has revealed that abusers frequently undermine their partner's health by withholding medication, altering prescriptions, cancelling medical appointments and even preventing their partners from sleeping.[18] It is therefore clear that GBV has a devastating impact on the health and well-being of women.

1 3 The role of the legal system

Historically the legal system has both established and entrenched unequal gender relations within our society. The advent of the social contract has thus been criticised for establishing a public/private law divide, which confined women to the private sphere and rendered the unequal power relations within this sphere as invisible and beyond state

[13] World Health Organization "Violence against Women Fact Sheet No 239" (2009) 1 <http://www.who.int/mediacentre/factsheets/fs239/en/> (accessed 10-11-2010); Heise et al "Violence by Intimate Partners" in *World Report on Violence and Health* (2002) 87.
[14] World Health Organization (2009) "Violence against Women Fact Sheet No 239 1; Heise et al "Violence by Intimate Partners" in *World Report on Violence and Health* (2002) 87.
[15] World Health Organization (2009) "Violence against Women Fact Sheet No 239 1.
[16] S Chant "Re-thinking the Feminisation of Poverty in Regard to Aggregate Gender Indices (2006) 7 *Journal of Human Development* 201 205.
[17] D Nath (One in Nine Campaign) "We were Never meant to Survive: Violence in the Lives of HIV Positive Women in South Africa" (2012) 1 25 <http://www.oneinnine.org.za/58.page> (accessed 04-06-2012).
[18] K Joyner *Health Care for Intimate Partner Violence: Current Standards of Care and Development of Protocol Management* DPhil thesis Stellenbosch University (2009) 1 77.

intervention.[19] Within South Africa the prevalence of colonialism, patriarchy and apartheid collectively perpetuated this inequality. Under apartheid the spatial planning laws combined with the migrant labour system contributed to the breakdown of African families, with women being primarily responsible for children.[20] This led to African women experiencing intersecting forms of disadvantage within our society.[21] In addition the common law rule of marital power was repealed as late as 1984,[22] marital rape was legal until 1992,[23] and the male primogeniture rule of customary law was recognised until 2005.[24]

Given that the law has sometimes compounded gender inequality, it is necessary to consider how the law can be developed so as to transform gendered social institutions and power imbalances.[25] In this regard, it is submitted that a transformative approach to the constitutional rights necessarily requires viewing these rights as interconnected and mutually reinforcing. In this manner the right to equality and the right to have access to health care services have the potential to form a powerful partnership.

---

[19] R Copelon "Recognizing the Egregious in the Everyday: Domestic Violence as Torture" (1994) 25 *Columbia Human Rights Law Review* 291 292.

[20] B Goldblatt "Citizenship and the Right to Child Care" in A Gouws (ed) *(Un)thinking Citizenship: Feminist Debates in Contemporary South Africa* (2005) 117 131.

[21] S Liebenberg & M O'Sullivan "South Africa's New Equality Legislation: A Tool for Advancing Women's Socio-Economic Equality?" (2001) 21 *AJ* 70 71. See *Brink v Kitshoff NO* 1996 4 SA 197 (CC); 1996 6 BCLR 752 (CC) where Justice O'Regan J states:

> "Although in our society, discrimination on grounds of sex has not been as visible, nor as widely condemned, as discrimination on grounds of race, it has nevertheless resulted in deep patterns of disadvantage. These patterns of disadvantage are particularly acute in the case of black women, as race and gender discrimination overlap. That all such discrimination needs to be eradicated from our society is a key message of the Constitution. The preamble states the need to create a new order in 'which there is equality between men and women' as well as equality between 'people of all races'" para 44.

[22] Section 11 of the Matrimonial Property Act 88 of 1984.

[23] Section 5 of the Prevention of Family Violence Act 133 of 1993.

[24] See *Bhe v Magistrate, Khayelitsha*; *Shibi v Sithole*; *South African Human Rights Commission v President of the Republic of South Africa* 2005 1 SA 580 (CC); 2005 1 BCLR 1 (CC). Where Pius Langa (then) Chief Justice stated:

> "The exclusion of women from inheritance on the grounds of gender is a clear violation of section 9(3) of the Constitution. It is a form of discrimination that entrenches past patterns of disadvantage among a vulnerable group, exacerbated by old notions of patriarchy and male domination incompatible with the guarantee of equality under this constitutional order" para 91.

[25] P Langa "Transformative Constitutionalism" (2006) 17 *Stell L R* 351 355.

In addition, a transformative approach includes interrogating the 'background legal rules,'[26] (such as the traditional divide between the public and private spheres and the distinction between positive and negative rights) and the true social impact of such distinctions. This is due to the fact that these traditional legal approaches are intimately interlinked with the prevalence of inequality within our society, such as the emphasis on civil and political rights, and the neglect of socio-economic rights (which predominantly affect women's lives). These traditional legal foundations therefore need to be effectively examined piece by piece to determine whether they truly serve us as a society dedicated to building a new constitutional order based on human rights and fundamental freedoms. While it is true that the legal system alone cannot create all of the necessary social change, it is an integral part of articulating the experiences of survivors of GBV (hereafter "SGBV") and in contributing to the change that needs to occur.[27]

1 4 Research aims, hypotheses and methodology

This study considers the gendered barriers to accessing health care services for SGBV. This analysis takes place within the social context of extreme levels of GBV, high levels of poverty and the gendered nature of the HIV/AIDS crisis in South Africa.

In relation to the jurisprudence on socio-economic rights, this thesis analyses how the right of access to health care services[28] and the right to equality[29] in the Constitution can be interpreted so as to stimulate a jurisprudence that is more responsive to the mutually reinforcing patterns of inequality and poverty in South Africa. As a point of departure it is assumed, that certain interpretations of the right to equality and the socio-economic rights have been unduly formalistic. Some interpretations of these rights have also been disengaged with the lived reality that many women experience. Therefore, the hypothesis guiding this analysis is that in order to provide authentic protection to these rights they need to be interpreted substantively and as mutually reinforcing. Relevant theory and

[26] L Williams "Issues and Challenges in Addressing Poverty and Legal Rights: A comparative United States/South Africa Analysis" (2005) 21 *SAJHR* 436 440.
[27] L Artz & D Smyth "Introduction: Should We Consent?" in L Artz & D Smyth (eds) *Should We Consent? Rape Law Reform in South Africa* (2008) 1 15.
[28] Section 27 of the Constitution of the Republic of South Africa, 1996 (hereafter "the Constitution".
[29] Section 9 of the Constitution.

literature on the meaning of our 'transformative constitutional culture', was thus consulted while constitutional provisions and jurisprudence were examined in exploring the interpretive potential of these rights to respond to GBV.

This thesis then examines relevant health legislation and policy interventions for SGBV in order to reveal existing gaps and shortcomings. As a point of departure, it is assumed that the current fragmented response by the government[30] is problematic and fails to respond to the needs of SGBV, in addition to the broader health care needs of women. Relevant theoretical literature on the gender dimensions of the right to health care services was consulted and attention was given to literature on empirical research (based on health care programmes and policies for abused women).

This is then followed by a consideration of how international law can contribute to the South African constitutional jurisprudence, and assist in broadening access to health care services for SGBV. It is assumed that international law can provide valuable guidance on developing an interpretation of the right of access to health care services which is effectively responsive to the needs of SGBV. This thesis therefore provides an analysis of relevant international and regional human rights instruments (including applicable general comments and decisions under complaints mechanisms) in order to consider how international law can contribute to South African law. Ultimately this thesis analyses how law and policy can be transformed to be more responsive to the needs and circumstances of SGBV, while seeking to outline an appropriate package of health care interventions to be provided to SGBV.

1 5 Overview of chapters

Chapter two will analyse the existing jurisprudence on the right to equality and the socio-economic rights. This will entail an analysis of the interrelationship between the equality and socio-economic rights in the Bill of Rights, and its potential to enhance the responsiveness of our jurisprudence to the reality of women's lives in South Africa. This

[30] L Vetten (Tshwaranang Legal Advocacy Centre) "Outlining the Rationale for a Health Sector Response to Domestic Violence" in *Developing a Health Sector Response to Domestic Violence: A Roundtable Discussion* (2008) 1 5 <http://www.tlac.org.za/images/documents/TLAC_Roundtable_web.pdf> (accessed 04-03-2011).

chapter will then examine how equality jurisprudence should be developed so as to be more responsive to material disadvantage and poverty.[31] Subsequently, this chapter examines how an equality perspective can enrich South Africa's jurisprudence on socio-economic rights.[32]

Chapter three will then provide an overview of the primary legislation enacted in order to give effect to these rights, such as the National Health Act 61 of 2003, the Domestic Violence Act 116 of 1998, and the right to health care for survivors of rape as contained within section 28 of the Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007. Thereafter the chapter provides an overview of the existing gaps and implementation problems facing this legislative and policy framework.

Chapter four will then consider relevant international law pertaining to the State's obligations in relation to health care services for SGBV. This is necessary as international obligations have been placed on the South African government. After considering the relevant international and regional treaties that South Africa has either signed or ratified, relevant non-binding international law will also be examined.

Chapter five will then apply the substantive equality and health care rights normative framework developed in chapters two and three, and the promising new developments within the international sphere (identified in chapter four) to outline an appropriate package of health care interventions to be provided to SGBV in order to fulfil their equal right to health care under our transformative Constitution.

1 6 Definition of gender-based violence

While the Domestic Violence Act 116 of 1998 provides a detailed definition of domestic violence, the most comprehensive definition of GBV can be found in international law. For example, the United Nations Committee on the Elimination of Discrimination against Women released General Recommendation 19 in 1992, which states that GBV is:

[31] S Liebenberg & B Goldblatt "The Interrelationship between Equality and Socio-Economic Rights under South Africa's Transformative Constitution" (2007) 23 *SAJHR* 335 335.
[32] Liebenberg & Goldblatt (2007) *SAJHR* 335.

> "Violence that is directed against a woman because she is a woman or that affects women disproportionately. It includes acts that inflict physical, mental or sexual harm or suffering, threats of such acts, coercion and other deprivations of liberty." [33]

The Declaration on the Elimination of Violence against Women by the General Assembly in 1993,[34] elaborated on the definition of GBV by highlighting the various forms of GBV.

Forms of GBV thus include family violence, community violence and State violence. Family violence includes the stalking, harassment, sexual, emotional, verbal, psychological, physical, and economic abuse of intimate partners and other family members. Community violence has been identified as female genital mutilation, rapes perpetrated by strangers (such as corrective rapes), the stalking of women, witch hunts, the sexual trafficking and exploitation of women and the sexual harassment of women and girls within the workplace and within schools. State violence has been identified as violence which is either perpetrated or condoned by people employed by the State, such as rapes committed by police or prison guards.

The primary focus of this thesis is on forms of GBV perpetrated within the family and within the community during the reproductive stage of life. This includes forms of violence perpetrated by intimate partners and all forms of rape.

[33] United Nations Committee on the Elimination of Discrimination against Women, General Recommendation No 19 *Violence against Women* (1992) (article 3 of the Convention) UN Doc A/47/38, para 6.
[34] United Nations General Assembly Declaration on the Elimination of Violence against Women (1993) UN Doc A/RES/48/104.

2 An interrelated interpretation of the right to equality and the right to have access to health care services.

2 1 Introduction

This chapter focuses on the interrelationship between the right to have access to health care services[1] and the right to equality[2] in the Constitution of the Republic of South Africa, 1996 (the "Constitution"). The primary focus of this chapter is to analyse how these rights can be interpreted so as to stimulate effective legislative and policy responses to gender-based violence (hereafter "GBV").

Expanding access to health care services is necessary as South Africa's history of colonialism and apartheid has resulted in race, class and gender determining access to public health care services.[3] A gender perspective is further necessary as women as a group, are disproportionately affected by poverty,[4] the HIV/AIDS epidemic[5] and inadequate health care services. As South Africa's Constitution is aimed at healing the divisions of the past,[6] the interpretive potential of these rights to respond to GBV and poverty will therefore be examined in light of our transformative Constitution.[7] While the exact meaning of transformation may be contested, I proceed from the understanding

[1] Section 27 of the Constitution of the Republic of South Africa, 1996 (the "Constitution").
[2] Section 9 of the Constitution.
[3] J Kehler "Women and Poverty: The South African Experience" (2001) 3 *Journal of International Women's Studies* 1 1.
[4] D Budlender "Women and Poverty" (2005) 64 *Agenda* 30 35 where she points out that:
> "While there are many different ways of measuring poverty, all suggest that women are more likely than men to live in poverty. This statement holds, whether we measure poverty simply by income, or use wider measures which encompass other aspects."

See also: J Dugard & N Mohlakoana "More Work for Women: A Rights -Based Analysis of Women's Access to Basic Services in South Africa" (2009) 25 *South African Journal on Human Rights* 546 546:
> "In South Africa, poverty is not gender-neutral. Women have less access to land and agriculture, and women make up only 38 per cent of the formal labour force. In terms of poverty indices, the poverty rate among female-headed households is 60 per cent, compared with 31 per cent for male-headed households."

[5] S Chisala "Rape and HIV/AIDS: Who's Protecting Whom?" in L Artz & D Smythe (eds) *Should We Consent?: Rape Law Reform in South Africa* (2008) 52 55.
[6] Preamble to the Constitution.
[7] "Transformative Constitutionalism" was a phrase first used and developed in a seminal article published by Karl Klare in 1998. See: K Klare "Legal Culture and Transformative Constitutionalism" (1998) 14 *SAJHR* 146 150.

that this entails a social and economic shift towards a more egalitarian society where all are able to access vital resources and reach their full human potential.[8]

After providing an overview of the normative framework of the relevant constitutional rights, the interdependent and interconnected nature of human rights will be analysed.[9] This interdependent approach is justified in light of the Constitutional Court's statement that all of the rights in the Bill of Rights are inter-related and mutually supporting.[10] Relevant equality jurisprudence will then be analysed. Through this analysis I will consider how the values underlying the socio-economic rights can assist such equality jurisprudence to be more responsive to material disadvantage.[11]

I will then provide a gendered analysis of relevant socio-economic jurisprudence to determine its responsiveness to the needs of South African women. In this regard the constraining effects of classic liberal conceptions of the law, such as a formal conception of rights, and a strict divide between public and private law will be considered. Given that access to vital resources is often shaped by power struggles within the private sphere,[12] an interrogation of these background legal rules is further necessary.[13] This will then be followed by an examination of how substantive equality,[14] with its focus on context, the impact of legal provisions, a positive recognition of difference and a reliance on values, can be streamlined into the reasonableness review model for adjudicating socio-economic rights. An analysis of the implications of such an interrelated interpretation for the right to have access to health care services in section 27 of the Constitution will then follow.

---

[8] P De Vos "*Grootboom,* the Right of Access to Housing and Substantive Equality as Contextual Fairness" (2001) 17 *SAJHR* 258 259; P Langa "Transformative Constitutionalism" (2006) 3 *Stell LR* 351 352; C Albertyn & B Goldblatt "Equality in the Final Constitution" Equality in S Woolman, T Roux & M Bishop (eds) *Constitutional Law of South Africa* 2 ed (Original Service June 2008) 35 -1 5.

[9] C Scott "The Interdependence and Permeability of Human Rights Norms: Towards A Partial Fusion of the International Covenants on Human Rights" (1989) 27 *Osgoode Hall Law Journal* 769 769.

[10] *Government of the Republic of South Africa v Grootboom* 2001 1 SA 46 (CC); 2000 11 BCLR 1169 (CC) para 23.

[11] S Liebenberg & B Goldblatt "The Interrelationship between Equality and Socio-Economic Rights under South Africa's Transformative Constitution" (2007) 23 *SAJHR* 335 335.

[12] M Pieterse "Relational Socio-Economic Rights" (2009) 25 *SAJHR* 198 198.

[13] L Williams "Issues and Challenges in Addressing Poverty and Legal Rights: A comparative United States/South Africa Analysis" (2005) 21 *SAJHR* 436 440.

[14] Cathi Albertyn identifies the elements of the judicial approach to substantive equality which includes attention to context, impact, difference and values. See: C Albertyn "Substantive Equality and Transformation in South Africa" (2007) 23 *SAJHR* 253 253.

2 2 Normative framework of relevant constitutional rights

2 2 1 Introduction

The Constitution provides for a progressive framework of rights that would appear highly conducive to combating GBV. Despite this progressive normative framework however, GBV has reached epidemic levels in South Africa,[15] with the implementation of such rights a continuing challenge.[16]

2 2 2 The right to equality and the right to have access to health care services

Equality is included in the Constitution as a value and a right. The founding provisions of the Constitution thus describe South Africa as a democratic State founded on human dignity, the achievement of equality and the advancement of human rights and freedoms and non-racialism and non-sexism.[17]

In *Minister of Finance v Van Heerden*[18] the importance of the value of equality was highlighted as not only a guaranteed and justiciable right in the Bill of Rights but also as a core and foundational value, a standard to which all law must adhere, and against which all law must be tested for constitutional consonance.[19]

Section 7 (1) of the Constitution describes the Bill of Rights as a cornerstone to democracy in South Africa, while section 7(2) specifically states that: "[t]he state must

[15] In South Africa, a woman is murdered every six hours by her intimate partner, while rape has reached endemic levels. See: S Mathews, N Abrahams, LJ Martin, L Vetton , L van der Merwe & R Jewkes "Every Six Hours a Woman is Killed by Her Intimate Partner" (2004) 5 *MRC Policy Brief* 11 <http://www.mrc.ac.za/policybriefs/woman.pdf> (accessed 15-02-2011). See also: South African Police Services: Crime Statistics Information Management on Sexual Offences <http://www.saps.gov.za/statistics/reports/crimestats/2011/categories/total_sexual_offences.pdf> (accessed 04-05-2012).

[16] L Vetten, T Le, A Leisegang & S Haken "The Right and the Real: A Shadow Report Analysing Selected Government Departments' Implementation of the 1998 Domestic Violence Act and 2007 Sexual Offences Act" (2011) 1 3 <http://www.boell.org.za/downloads/The_Right_and_The_Real.pdf> (accessed 12-10-2011).

[17] Preamble to the Constitution.

[18] 2004 11 BCLR 1125 (CC), 2004 6 SA 121 (CC).

[19] *Minister of Finance v Van Heerden* 2004 11 BCLR 1125 (CC), 2004 6 SA 121 (CC) para 22.

respect, protect, promote and fulfil the rights in the Bill of Rights." Section 8(2) of the Constitution also states that a provision of the Bill of Rights binds both natural and juristic persons.

As a right, section 9 (1) provides that everyone is equal before the law, and that everyone has the right to equal protection and benefit of the law. Section 9(2) goes on to state that equality includes the full and equal enjoyment of all the rights in the Bill of Rights, illustrating its interconnection to other fundamental rights. Section 9(2) also provides that positive legislative and other means may be utilised in order to advance individuals and groups that have experienced past discrimination. Section 9(3) and 9(4) prohibit unfair discrimination by the State and by private individuals, respectively. Section 9(3) specifically provides a list of grounds of discrimination which includes gender, race, sex and social origin, while section 9(5) specifically states that discrimination on any of these listed grounds is presumed to be unfair discrimination. The Constitution also includes the rights to human dignity (section 10), life (section 11) and freedom and security of the person (section 12).

In relation to health care, section 24(a) provides for the services necessary for an environment that is not harmful to one's health. Section 26 provides that everyone has the right to have access to adequate housing. Of particular importance however, is section 27(1) (a) which states that everyone has the right to have access to health care services, including reproductive health care. Section 27(2) goes on to state that "reasonable measures" must be taken to achieve the progressive realisation of this right "within available resources." Section 27(3) further states that no one may be refused emergency medical treatment. In relation to the interpretation of the Constitution, section 39(1)(a) mandates that when interpreting the Bill of Rights a court must promote the values that underlie an open and democratic society based on human dignity, equality and freedom. Section 39(1)(a) thus emphasises the interpretive importance of the value of equality. Section 195 of the Constitution further requires that public administration be governed by democratic principles while being responsive to people's needs.

2 2 3 The interrelated nature of constitutional rights

In order to lead a full and dignified human life, people require a complex set of interconnected social, economic and political resources. In this regard, the human capabilities approach, developed by Amartya Sen and Martha Nussbaum considers the extent to which human beings are able to be do and have what they have reason to value, and the degree to which material deprivation hinders such freedom. [20] The capabilities approach reveals that both the socio-economic rights and the civil and political rights influence the ability to fulfil one's human potential. In accordance with this recognition, women's poverty has been described as a central manifestation of women's lesser social and economic power. In turn, it has been pointed out that women's poverty reinforces their social subordination, making them more vulnerable to violence and exploitation.[21]

The interconnection between human rights is further illustrated by Sandra Liebenberg, who points out that without an education, the right to freedom of expression may not be fully utilised.[22] Likewise, the right to equality and the right to freedom and security of the person are impoverished if health care services are provided in a discriminatory and abusive manner. The inclusion of both socio-economic and civil and political rights in the Constitution has been further highlighted as recognition of the interdependent nature of human rights.[23]

This is also relevant in relation to section 27(1) (a) of the Constitution, in that adequate health care is necessary for one to develop one's full human potential, and to achieve parity of participation in our society. [24] Particularly for women, quality sexual and reproductive health care services are also required in order to protect their autonomy, their dignity and their right to life. [25] Inadequate public health care services further

[20] A Sen "Human Rights and Capabilities" (2005) 6 *Journal of Human Development* 151 152; M Nussbaum "Introduction: Feminism and International Law" in *Women and Human Development: The Capabilities Approach* (2000) 1 2.
[21] International Federation for Human Rights, *Montreal Principles on Women's Economic, Social and Cultural Rights* (2002) 2.
[22] S Liebenberg *Socio-Economic Rights: Adjudication under a Transformative Constitution* (2010) 52.
[23] Liebenberg & Goldblatt (2007) *SAJHR* 338.
[24] M Pieterse "The Interdependence of Rights to Health and Autonomy in South Africa" (2008) 125 *SALJ* 553 555.
[25] M I Plata "Reproductive Rights as Human Rights" in R Cook (ed) *Human Rights of Women: National and International Perspectives* (1994) 515 528.

compound the burden of caring work that many women take on. [26] This interdependence further reveals that the most vulnerable members of our society often suffer from intersecting forms of marginalisation. To ignore the interdependent nature of such rights would therefore be to ignore the reality of human suffering.[27]

If the value of equality is to inform all law,[28] it is thus necessary to consider the extent to which the right to have access to health care services can be broadened so as to foster substantive gender equality in South Africa. In this regard it is imperative that interpretations of the right to have access to health care services are grounded in the lived experiences of women. Likewise, in order for interpretations of the right to equality to be more responsive to the feminisation of socio-economic burdens, the intersecting nature of material deprivation and gender inequality also needs to be considered.

2 3 Equality Jurisprudence

2 3 1 Introduction

Since the advent of our Constitution, there have been certain equality judgments that have resulted in discernible positive change.[29] However, certain decisions addressing unfair discrimination have simply broadened social inclusion while failing to dislodge the underlying conditions that promote inequality. [30] Feminists have thus criticised the judiciary, stating that the transformative potential of the Bill of Rights has been undermined through the role of the courts and the limits of justiciability. [31] Relevant equality jurisprudence will therefore be examined in order to determine the degree to

[26] Kehler (2001) *Journal of International Women's Studies* 6, where she states that :
"Women carry the brunt of the burden of finding alternatives for lack of service provision or when services are inaccessible due to costs."
[27] Scott (1989) *Osgoode Hall Law Journal* 778.
[28] *Minister of Finance v Van Heerden* 2004 11 BCLR 1125 (CC), 2004 6 SA 121 (CC) para 22.
[29] For example, in *National Coalition for Gay and Lesbian Equality v Minister of Justice* (1999) 1 SA 6 (CC); 1999 3 BCLR 280 (CC), the Constitutional Court recognised the equal rights of gay men by holding that the common law crime of sodomy was a discriminatory prohibition on sex between men which constituted unconstitutional unfair discrimination on the protected ground of sexual orientation (section 9(3) of the Constitution); (paras 20-21).
[30] Albertyn (2007) *SAJHR* 254.
[31] Albertyn (2007) *SAJHR* 273.

which such decisions fulfil the transformative vision of the Constitution, particularly in relation to equal access to socio-economic resources.

The test for unfair discrimination was first developed in *Harksen v Lane NO and Others.*[32] The first aspect of the enquiry is whether an impugned provision differentiates between people or groups of people. The court then needs to determine if the differentiation amounts to discrimination and if such discrimination is unfair.[33] If such discrimination is found to be unfair then it needs to be justified in terms of the limitations clause (section 36).

However, many subsequent applications of this test have simply maintained the status quo by preserving conservative ideas on gender, sexuality, family and marriage.[34] In certain cases the courts have also been criticised for conflating the dignity and equality considerations, while neglecting the vital material interests of certain applicants.[35] Furthermore, the Constitutional Court's adoption of a formal approach to equality and a liberal conception of choice have impeded the ability of the legal system to respond to the reality of women's lives. This is in deep contrast to the interpretation of section 9 as a commitment to substantive equality.[36]

The Constitution also protects the right to enjoy freedom and security of the person (section 12), which includes the right to be free from public or private violence, on an equal basis. In this regard, the Constitutional Court has developed a progressive jurisprudence that recognises the magnitude of GBV in South Africa.[37] The jurisprudence

---

[32] 1997 11 BCLR 1489 (CC) ; 1998 1 SA 300 (CC).

[33] I Currie & J De Waal *The Bill of Rights Handbook* 5 ed (2005) 243-245. Discrimination is defined as differential treatment on illegitimate grounds. Differentiation based on a listed ground mentioned in section 9(3), is presumed to be unfair discrimination. The Court has also recognised analogous grounds not listed in section 9(3), including HIV/AIDS in *Hoffman v South African Airways* 2001 1 SA 1 (CC); 2000 11 BCLR 1235 (CC). If such differentiation is not based on a listed ground then the applicant must prove that it is unfair discrimination. Currie and De Waal describe unfair discrimination as discrimination that entrenches existing inequality.

[34] Albertyn (2007) *SAJHR* 255.

[35] C Albertyn & B Goldblatt "Facing the Challenge of Transformation: Difficulties in the Development of an Indigenous Jurisprudence of Equality" (1998) 14 *SAJHR* 248 258.

[36] Justice Sachs emphasised this in *Volks NO v Robinson* 2005 5 BCLR 446 (CC) with the statement that: "This Court has on numerous occasions stressed the importance of recognising patterns of systematic disadvantage in our society when endeavouring to achieve substantive and not just formal equality." (Para 163).

[37] See *Carmichele v Minister of Safety and Security and Another* 2001 4 938 (CC): 2001 10 BCLR 995 (CC) where the Constitutional Court held that:

has also recognised that GBV goes to the core of women's subordination, while developing the positive duty on the State to protect women against such violence.[38]

Despite such progressive developments however, the judicial approach to the right to equality has often failed to dislodge the underlying generative basis of gender inequality, while often entrenching negative gender stereotypes.[39] Through an examination of the relevant equality jurisprudence, I will analyse how the values underlying the socio-economic rights can increase sensitivity to the intersecting nature of inequality, while strengthening the redistributive and transformative aspects of substantive equality.

2 3 2 *President of the Republic of South Africa v Hugo*: The transformative potential of section 9

The reluctance of the Constitutional Court (hereafter "the Court") to address the redistributive and transformative aspects of substantive equality was illustrated in the case of *President of the Republic of South Africa v Hugo (*hereafter *"Hugo").*[40] This was

---

"Sexual violence and the threat of sexual violence goes to the core of women's subordination in society. It is the single greatest threat to the self-determination of South African women." (Para 45).

In *Omar v Government of the Republic of South Africa and* Others (Commission for Gender Equality, Amicus Curiae) 2006 2 SA 289 (CC); 2006 2 BCLR 253 (CC) the Constitutional Court dealt with the constitutionality of section 8(1) of the Domestic Violence Act 116 of 1998 which allows a court to issue a suspended warrant of arrest. The Court held that that Act was constitutional and Justice Van der Westhuizen confirmed that:

"The high incidence of domestic violence in our society is utterly unacceptable. It causes severe psychological and social damage. There is clearly a need for an adequate legal response to it." (Para 13).

[38] *Carmichele v Minister of Safety and Security and Another* 2001 4 938 (CC); 2001 10 BCLR 995 (CC) first recognised the duty to protect women from violence (para 62). This was subsequently developed in *K v Minister of Safety and Security* 2005 6 SA 419 (CC); 2005 9 BCLR 835 (CC). The decision *of F v Minister of Safety and Security* 2012 1 SA 536 (CC); 2012 3 BCLR 244 (CC) however, developed vicarious liability even further by deciding that the Minister of Safety and Security could be held liable for an act of rape performed by an off duty policeman.

[39] For example, in *S v Zuma* 2006 2 SACR (W*)* the court referred to the fact that Zuma had believed that the complainant had consented to sexual intercourse because the complainant had worn a skirt with no panties and because she hadn't cried out or physically fought back during intercourse. Judge Willem van der Merwe wrote on page 159 of his decision:

"The following should be emphasised ... In the accused's house the complainant walked around in a kanga with no underwear which prompted Duduzile Zuma to say she was inappropriately dressed."

This case has been criticised extensively for perpetuating the stereotype that women's clothing can be provocation enough for rape. See L Vetten, Tshwaranang Legal Advocacy Centre "Of Taxis and Trials: Snapshots from the Struggle for Gender Equality" 48 49 (2008) <http://www.tlacporg.za/index.php?option=content&task=view&id=250 > (accessed 12-06-2011).

[40] *President of the Republic of South Africa v Hugo* 1997 4 SA 1 (CC); 1997 6 BCLR (CC).

one of the first cases in which the Court had to consider a claim for equality. In this case a male claimant was challenging a Presidential Act calling for the release of all female prisoners with children under the age of twelve, on the basis that it discriminated against him, on the grounds of sex or gender and indirectly against his son because his incarcerated parent was not a female.

When analysing the impact of the Presidential Act the Court pointed out that the disadvantage the claimant experienced was not as a result of the Act, but a result of his conviction.[41] Ultimately, the Court found that while it amounted to discrimination, it was not unfair discrimination in light of the burden of child-care that many women experience.[42] The Court therefore took judicial notice of the reality that in our society mothers are primarily responsible for the care of small children.[43] The Court further recognised that the burden of child-care has exacerbated gender inequality in numerous other areas with the statement that:

> "The result of being responsible for children makes it more difficult for women to compete in the labour market and is one of the causes of the deep inequalities experienced by women in employment. The generalisation upon which the President relied is therefore a fact which is one of the root causes of women's inequality in our society."[44]

While the judgment in *Hugo* was laudable for recognising the reality of women's lives, the Court struggled with the tension between the need to address women's current conditions of inequality and the need to transform them.[45] The Court's inability to transcend this tension through recognising such disadvantage while asserting a more equal conception of our society[46] thus constrained the transformative potential of the right to equality.

---

[41] *President of the Republic of South Africa v Hugo* 1997 4 SA 1 (CC); 1997 6 BCLR (CC) para 48.
[42] *President of the Republic of South Africa v Hugo* 1997 4 SA 1 (CC); 1997 6 BCLR (CC) para 47.
[43] *President of the Republic of South Africa v Hugo* 1997 4 SA 1 (CC); 1997 6 BCLR (CC) para 37.
[44] *President of the Republic of South Africa v Hugo* 1997 4 SA 1 (CC); 1997 6 BCLR (CC) para 38.
[45] While the case was applauded by many for the judicial recognition of the burden of child-care borne by women, and how this has resulted in severe inequality Professor Cathi Albertyn has pointed out that:
"The judgment's reliance on women's role as mothers (was done) in a manner that reinforced, rather than transformed, stereotypical gender roles." See Albertyn (2007) *SAJHR* 263.
[46] Alberyn (2007) *SAJHR* 263.

This decision has also been criticised for shifting the focus from group-based material disadvantage to a conflation between the right to equality and the right to dignity.[47] Particularly Justice Goldstone's description of equality as according "[e]qual dignity and respect"[48] has been criticised for reducing the right to equality to the right to dignity. This resulted in the central aspects of the right to equality, with its focus on disadvantage, vulnerability and harm being neglected by the Court.[49]

The Court's approach is understandable to a degree, in light of this being one of the first cases dealing with equality in our post constitutional democracy. However, the Court should have guarded against unintentionally entrenching negative gendered stereotypes, such as the gendered nature of child-care, in a more careful manner. The Court should also have attempted to consider the right to equality in a manner that was consistent with the transformative goal of shifting social institutions and power imbalances. Such an approach requires more than simply recognising women's disadvantage, it also requires redistributive steps to dislodge the status quo.

2 3 3 *S v Jordan*: Intersecting inequality

In *S v Jordan* [50] (hereafter "*Jordan*"), the Court failed to consider the interconnection between gender and poverty which resulted in a formalistic and a-contextual judgment. In this case, the majority of the Constitutional Court held that section 20(1) (A) of the Sexual Offences Act 23 of 1957, which criminalised the selling of sex 'by any person' but not the buying of sex, was not discriminatory towards women. Justice Ngcobo held that: "The section clearly applies to male prostitutes as well as to female prostitutes. The section is therefore gender-neutral."[51] He also went on to state that gender was not a differentiating factor in relation to sex work.[52]

---

[47] Albertyn & Goldblatt (1998) *SAJHR* 258.
[48] *President of the Republic of South Africa v Hugo* 1997 4 SA 1 (CC); 1997 6 BCLR (CC) para 41.
[49] Albertyn & Goldblatt (1998) *SAJHR* 258.
[50] *S v Jordan (Sex Workers Education & Advocacy Task Force as Amicus Curiae)* 2002 6 SA 642 (CC); 2002 11 BCLR 1117 (CC).
[51] *S v Jordan (Sex Workers Education & Advocacy Task Force as Amicus Curiae)* 2002 6 SA 642 (CC); 2002 11 BCLR 1117 (CC) para 9.
[52] *S v Jordan (Sex Workers Education & Advocacy Task Force as Amicus Curiae)* 2002 6 SA 642 (CC); 2002 11 BCLR 1117 (CC) para 15.

These statements appear to be disconnected from the social context within which the law is operating in that the majority of sex workers are in fact female. These women also disproportionately bear the consequences of sex work, such as injuries from violence and harassment, post-traumatic stress disorder, and increased exposure to HIV/AIDS and STD's.[53] Choosing to only criminalise the sex worker therefore effectively entrenches these vulnerabilities in addition to unequal social relationships, all of which is blatantly contrary to the spirit of our transformative Constitution.

In *Jordan*, the Court had the opportunity to recognise the stigma, stereotyping and violence that sex workers experience, in addition to the manner in which existing power structures and socio-economic circumstances facilitate this.[54] However, the majority judgment focused on the selling of sex as an individual choice, divorced from social institutions such as poverty. In contrast to blaming sex workers for their denigration, the majority of the Court could have undertaken a more realistic assessment of what leads women to resort to sex work. While the Court acknowledged in *Hugo*, that the majority of women take on the responsibility of caring for children, no recognition was given to this gendered socio- economic burden within the majority judgment in *Jordan*.

When addressing impact, the Court went on to state that "negative stereotypes attached to prostitution did not emanate from the law but by virtue of the conduct they

---

[53] *S v Jordan (Sex Workers Education & Advocacy Task Force as Amicus Curiae)* 2002 6 SA 642 (CC); 2002 11 BCLR 1117 (CC) para 87; Counsel for the applicant specifically pointed out that the marginalisation of sex workers by the law renders these women vulnerable to violence as they are forced to work in isolated circumstances and because they fear reporting assaults to the police. See also: M Farley, I Baral, M Kiremire, U Sezgin, "Prostitution in Five Countries: Violence and Posttraumatic Stress Disorder" (1998) 8 *Feminism & Psychology* 405 426. In this article prostitution is described as intrinsically traumatising:

> "In a study of 475 people in prostitution (including women, men, and the transgendered) from five countries (South Africa, Thailand, Turkey, USA, and Zambia): 62% reported having been raped in prostitution, 73% reported having experienced physical assault in prostitution, 72% were currently or formerly homeless and 92% stated that they wanted to escape prostitution immediately."

[54] E Bonthuys "Institutional Openness and Resistance to Feminist Arguments: The Example of the South African Constitutional Court" (2008) 20 *CJWL/RFD* 1 17. See also: G Brodsky & S Day "Denial of the Means of Subsistence as an Equality Violation" (2005) *AJ* 149162 who confirm that:

> "Poverty forces women to accept sexual commodification and subordination to men in order to survive. They engage in prostitution or 'survival sex' to get by. They lose autonomy to choose freely with whom and when they will have sex, and even whether and when they will have children. They are more vulnerable to rape, assault and sexual harassment because they live in unsafe places, and they are not free to walk away from workplaces that are poisoned. They are not free to leave abusive relationships when destitution is the alternative."

engage in."[55] This limits the contextual analysis of the impact of such legislation on systemic patterns of inequality and thus undermines a culture of justification.[56] Such an approach is further damaging for the actualisation of health-related rights, and equality rights, as it denies social complicity in the creation of health problems and unequal relationships.[57] It is submitted, that if social arrangements have resulted in the need to resort to sexual exploitation in order to survive, then we need to consider how to address this reality in a manner that is consistent with the transformative ethos of our Constitution.

In contrast to the formal approach adopted by the majority judgment, the minority judgment was able to recognise that women often turn to prostitution out of necessity[58] and that sex work is approached in a multitude of ways in other countries.[59] The minority judgment also recognised that treating sex workers as social outcasts while failing to criminalise the men who procure their services illustrates the different social standards applied to men and women's sexuality. Despite the recognition of how this sexist stigma fosters gender inequality,[60] the minority confirmed the statement by the majority that the legislation does not infringe upon sex workers' rights to dignity. Instead, they held that women who engage in prostitution erode their own constitutional dignity.[61] While the minority judgment ultimately found that only criminalising the sex worker did amount to unfair discrimination, [62] their discussion on the right to privacy revealed sustained conventional ideas:

---

[55] *S v Jordan (Sex Workers Education & Advocacy Task Force as Amicus Curiae)* 2002 6 SA 642 (CC) para 16.
[56] E Mureinik "A Bridge to Where? Introducing the Interim Bill of Rights" (1994) 10 *SAJHR* 31 32.
[57] Pieterse (2008) *SALJ* 555.
[58] *S v Jordan (Sex Workers Education & Advocacy Task Force as Amicus Curiae)* 2002 6 SA 642 (CC) para 68:
> "The evidence suggests that many women turn to prostitution because of dire financial need and that they use their earnings to support their families and pay for their children's food and education."

[59] *S v Jordan (Sex Workers Education & Advocacy Task Force as Amicus Curiae)* 2002 6 SA 642 (CC) para 90.
[60] *S v Jordan (Sex Workers Education & Advocacy Task Force as Amicus Curiae)* 2002 6 SA 642 (CC) para 64.
[61] *S v Jordan (Sex Workers Education & Advocacy Task Force as Amicus Curiae)* 2002 6 SA 642 (CC) para 74.
[62] *S v Jordan (Sex Workers Education & Advocacy Task Force as Amicus Curiae)* 2002 6 SA 642 (CC) para 71 and para 98.

> "[b]y making her sexual services available for hire to strangers in the marketplace, the sex worker empties the sex act of much of its private and intimate character. She is not nurturing relationships or taking life affirming decisions about birth, marriage or family. She is making money."[63]

In this case the interpretation to the right to equality may have been better served by a deeper engagement with the material deprivation that is experienced by the majority of sex workers in South Africa. The Court could also have recognised that there are some women who are trafficked for the purposes of forced sex work. To further punish such women will only entrench their disadvantage and their suffering. Given that the minority judgment was able to consider the broader social context for the majority of sex workers in South Africa, this contextual analysis could therefore have been further developed by the majority of the Court. The Court could have also acknowledged society's role in compounding the suffering of the poor, and in facilitating the demand for sex workers. In contrast, this judgment simply reinforced gendered stereotypes and did nothing to alleviate the plight of destitute women, particularly sex workers.

2 3 4 *Volks NO v Robinson*: The impact of socio-economic circumstances on the capacity to exercise choice

In *Volks NO v Robinson*[64] (hereafter "*Volks*") the Court had to determine the constitutionality of the Maintenance of Surviving Spouses Act 27 of 1990. The Act was placed under scrutiny for its exclusion of partners in co-habiting relationships, with the applicant claiming that it discriminated unfairly on the basis of marital status and gender. As marital status is included as a listed ground under section 9(3), Skweyiya J (writing for the majority) was prepared to accept that it was presumed unfair discrimination. Ultimately however, Skewyiya's judgment found that because marriage is a vital social

[63] *S v Jordan (Sex Workers Education & Advocacy Task Force as Amicus Curiae)* 2002 6 SA 642 (CC) para 83.
[64] 2005 5 BCLR 446 (CC).

institution, serving as the bases of our society, it was not unfair to distinguish between those who were married and those who were not.[65]

This uncritical prioritisation of marriage is problematic however, as marriage relationships are perfectly capable of becoming sites of exploitation and abuse.[66] The extreme levels of domestic violence in South Africa clearly illustrate this. However, this decision is particularly troublesome given that the lack of legal protection of cohabitation [67] and men's ability to use violence, has effectively entrenched the subordination and material insecurity experienced by many poor South African women.[68] For example, the failure to legally recognise cohabitation prevents poor women from claiming a duty of support from their partner. They are also excluded from inheriting from their partner's estate, unless their partner specifically nominates them as a beneficiary.[69] Given that many poor women do not have the power to insist that their partner marry them or appoint them as a beneficiary, this consequently places them at the mercy of their partner, particularly if they rely on them for material support.

This decision has thus been criticised for its prioritisation of marriage, and its failure to engage with the manner in which marriage has been historically racialised and gendered.[70] The conservative approach to marriage in this decision was also out of touch with the pluralistic reality of South African society, particularly as over a million South Africans are cohabiting.[71] This conservative approach was further surprising as the Court had the benefit of the High Court Judgment which provided substantial recognition of the manner in which privileging marriage over other forms of relationships infringes upon equality and dignity:

---

[65] *Volks NO v Robinson* 2005 5 BCLR 446 (CC) paras 52-54.
[66] F E Olsen "The Myth of State Intervention in the Family" (1984) 18 *University of Michigan Journal of Law Reform* 835 836.
[67] While there is currently the Domestic Partnerships Bill of 2008, which makes provision for registered and unregistered domestic partnerships, this Bill has yet to be enacted into law.
[68] B Goldblatt "Regulating Domestic Partnerships-*A Necessary Step in the Development of South African Family Law*" (2003) 120 *SALJ* 610 615.
[69] L Gerntholtz & N Nsibandeby (Centre for the Study of Violence and Reconciliation) "Using the Law to Secure Women's Rights to Housing and Security of Tenure: A Brief Examination of Some Key Aspects of Family and Customary Law and Domestic Violence Legislation" (2006) 1 4.
[70] Albertyn (2007) *SAJHR* 266.
[71] Goldblatt (2003) *SALJ* 610.

> "To ignore the arrangement and impose a particular religious view on their world is to undermine the dignity of difference and to render the guarantee of equality somewhat illusory insofar as a significant percentage of the population is concerned."[72]

Despite the Court's limited recognition of the reality that the structural dependence of women in such relationships often leaves them destitute,"[73] the Court failed to respond to such disadvantage in a manner that gave substantive content to the right to equality.

This judgment further reinforced a formalistic conception of choice and equality that was detrimental to vulnerable members of families. This was illustrated in the Court's liberal conception of choice as free and unconstrained.[74] This approach perceived a stark distinction between those with 'free will' (the applicant) and those without. Even if the applicant had had the 'choice' to marry, the Court could have considered this case within its broader social context, where poor women are often severely disadvantaged by the non-recognition of their relationships. This "moral conservatism" therefore resulted in the application of formal equality, while failing to recognise the nuances of powerlessness that many poor women experience in relationships.[75]

In contrast to this, the minority judgment of Justice Sachs was more in tune with the contextual reality of gender inequality, while critical of the majority's endorsement of legal neutrality. He described patriarchy and sexism as so ancient and entrenched[76] that they appear to be natural and invisible. He went on to state that the constitutional consideration of unfair discrimination requires an in depth scrutiny of the manner in which the law reinforces gender inequality.[77] He further pointed out that the key consideration

---

[72] *Robinson and Another v Volks NO and Others* 2004 (6) SA 288 (C) at 299I; 2004 (6) BCLR 671 (C) at 682H.
[73] *Volks NO v Robinson* 2005 5 BCLR 446 (CC) para 63.
[74] Bonthuys (2008) *CJWL/RFD* 13- 14.
[75] For an overview of the nuances of inequality in cohabiting relationships see: Goldblatt (2003) *SALJ* 616, where she points out that:

> "The libertarian presumption of free choice is incorrect. It is itself premised on the idea that all people entering into family arrangements are equally placed. This is not so. Men and women approach intimate relationships from different social positions with different measures of bargaining power. Gender inequality and patriarchy result in women lacking the choice freely and equally to set the terms of their relationships. It is precisely because weaker parties (usually women) are unable to compel the other partner to enter into a contract or register their relationship that they need protection."

[76] *Volks No v Robinson* 2005 5 BCLR 446 (CC) para 163.
[77] *Volks No v Robinson* 2005 5 BCLR 446 (CC) para 163.

was whether the relationship was deserving of protection and whether it was unfair to leave the surviving partner without any means of support because they were unmarried. This minority judgment therefore illustrated that a more substantive and realistic consideration of the reality of women's lives was indeed possible.

An analysis of the impact of such legislation could therefore have included an analysis of how this legislation entrenched existing gendered patterns of socio-economic disadvantage. Given that poverty is particularly gendered, the material deprivation experienced by many cohabiting women in South Africa could have received more attention. In light of all the above it is necessary to consider how the values and interests underlying the socio-economic rights can enrich such decisions.

2 3 5 Enriching equality jurisprudence through the values and interests underlying the socio-economic rights

Sandra Liebenberg and Beth Goldblatt advocate for a form of related interpretation known as 'interpretative interdependence,'[78] between the socio-economic rights and the right to equality. This approach treats the two rights as separate but complementary, effectively considering how the values and purposes underpinning one right (for example equality) may be relevant and useful to the development of the jurisprudence on the other right (such as the right of access to health care services).

An interrelated interpretation within the holistic scheme of the entire Bill of Rights has been specifically approved by the Court in the case of *Government of the Republic of South Africa v Grootboom and Others*.[79] The Court stated that:

> "The proposition that rights are interrelated and are all equally important is not merely a theoretical postulate. The concept has immense human and practical significance in a society founded on human dignity, equality and freedom. It is fundamental to an evaluation of the

[78] Liebenberg & Goldblatt (2007) *SAJHR* 339.
[79] *Government of the Republic of South Africa v Grootboom* 2001 1 SA 46 (CC); 2000 11 BCLR 1169 (CC).

reasonableness of state action that account be taken of the inherent dignity of human beings."[80]

It is therefore submitted that an interrelated approach can thus enrich the consideration of unfair discrimination in the following manner:

(i) An interrelated interpretation can assist in ensuring that the contextual analysis is more responsive to the material deprivation experienced by the applicant.[81] This could shift the focus back onto group-based understandings of material disadvantage, and prevent the conflation of dignity and equality.[82] Adding considerations of material disadvantage to the analysis would also reveal the manner in which poverty exacerbates gender inequality. This would further reveal the multi-dimensional nature of poverty and gender equality and thus facilitate a more responsive jurisprudence on equality.

(ii) Equality arguments can further take account of socio-economic rights as tools to redress issues of material disadvantage based on status. The strong correlation between status inequality and poverty therefore means that the right of everyone to access socio-economic goods can positively reinforce the redistributive dimension of section 9(2).

(iii) This interrelationship has the additional potential to recognise particular needs while preventing the 'levelling down' of services in the name of equality. While equality can be used to justify treating people equally badly, socio-economic rights call for the progressive realisation of these rights. Negative infringements on socio-economic rights are also subject to the stringent requirements of the limitations clause (section 36).

Furthermore, while section 9(2) could possibly be used to justify failing to assist other disadvantaged groups in our society, section 27 specifically states that 'everyone' has the right to have access to health care services. Section 9(2) also provides for positive measures to address inequality, providing support for the provision of services that are tailored to the needs of particular groups. This is consistent with the observation by Amartya Sen that substantive equality "may demand very unequal treatment in favour of

[80] *Government of the Republic of South Africa v Grootboom* 2001 1 SA 46 (CC); 2000 11 BCLR 1169 (CC) para 83.
[81] Liebenberg & Goldblatt (2007) *SAJHR* 336.
[82] Albertyn & Goldblatt (1998) *SAJHR* 257.

the disadvantaged, when there is a good deal of antecedent inequality to counter."[83] This interrelated approach therefore ensures a more balanced method between guarding against the neglect of particular groups, and the need for special measures to advance particularly vulnerable groups within our society.

It is therefore submitted, that an interrelated interpretation has the potential to facilitate a more realistic recognition of the myriad of socio-economic conditions that facilitate the degradation and exploitation of women.[84] Such an approach can further facilitate a more balanced, flexible and nuanced approach to the determination of unfair discrimination in our society. In order to analyse the possible contribution that equality, as a value and a right could have on the adjudication of the socio-economic rights, an overview of the relevant socio-economic jurisprudence is necessary.

2 4 Socio-economic jurisprudence: An engendered overview

2 4 1 Introduction

Despite the celebrated judgment of *Government of the Republic of South Africa v Grootboom,*[85] and the positive consequences of *Minister of Health v Treatment Action Campaign,*[86] certain socio-economic decisions have been criticised for emphasising procedural criteria, in contrast to the substantive values and interests that the socio-economic rights are intended to protect.[87] The Socio-economic jurisprudence has further

[83] A Sen *Inequality Re-examined* (1992) 1.
[84] Dugard & Mohlakoana (2009) *SAJHR* 548:
"Insufficient access to resources such as water and electricity increase women's vulnerability to sexual exploitation and gender violence in the home. For this reason it can be said that both poverty and basic services have a gender."
[85] 2001 1 SA 46 (CC); 2000 11 BCLR 1169 (CC).
[86] (No 2) 2002 5 SA 721 (CC).
[87] D Brand "What are Socio-Economic Rights For?"' in H Botha, A van der Walt & J van der Walt (eds) *Rights and Democracy in a Transformative Constitution* (2004) 33 36; M Pieterse "Coming to Terms with Judicial Enforcement of Socio-Economic Rights" (2004) 20 *SAJHR* 383 410. Liebenberg *Socio-economic Rights* 175-176.

been criticised for failing to address the gendered barriers to accessing these rights, with the statement that poverty is always, also, a matter of gender inequality.[88]

The obligation under section 7(2) to promote and fulfil the constitutional rights expands the notion that the socio-economic rights only entail negative duties.[89] The socio-economic rights thus entail both positive and negative rights, with the Court having adopted distinctive methods in adjudicating claims to such rights. In relation to the obligation to take positive steps, the right to have access to health care services has been limited by section 27(2) which states that "reasonable measures" must be taken to achieve the progressive realisation of this right "within available resources."

The Court has yet to provide a detailed account of what these positive obligations entail. It has, however, adopted reasonableness review which incorporates certain criteria for assessing compliance by the State with its positive duties. This entails an inquiry into whether a government programme is flexible, coherent, comprehensive and capable of effectively realising the particular socio-economic right.[90] A further factor is the degree to which provision has been made for the most vulnerable members of our society.[91]

In relation to negative duties, when individuals or groups are deprived of existing access to socio-economic goods, this is perceived as negative infringements on the socio-economic rights. This infringement requires justification in terms of section 36, which requires that the infringement must be based on a law of general application and justifiable in light of the constitutional vision of a society based on human dignity, equality and freedom.

While criticism has been levelled against utilising equality to strengthen the socio-economic rights,[92] it has been argued that the gendered and racial patterns of socio-

[88] C Albertyn "Gendered Transformation in South African Jurisprudence: Poor Women and the Constitutional Court" (2012) 22 *Stell LR* 591 600.
[89] Liebenberg *Socio-Economic Rights* 82.
[90] *Government of the Republic of South Africa v Grootboom* 2001 1 SA 46 (CC); 2000 11 BCLR 1169 (CC) paras 40-46.
[91] *Government of the Republic of South Africa v Grootboom* 2001 1 SA 46 (CC); 2000 11 BCLR 1169 (CC) para 44.
[92] D Bilchitz *Poverty and Fundamental Rights: The Justification and Enforcement of Socio-Economic Rights* (2007) 170 170–176. Bilchitz effectively points out the limits of an equality consideration, in that equality is only a relative concept, automatically requiring a comparator.

economic deprivation in South Africa, warrants the further development of the value of equality within reasonableness review.[93] The criticism against equality is that it is a "comparative notion," unable to provide substantive standards to measure State conduct, while failing to answer the integral question of "equality of what?"[94] While this criticism is warranted, in the context of GBV- a gender-neutral approach will be counter-productive. This is due to the fact that women experience violence differently to men. They are also disproportionately affected by such violence, while they have specific health care needs, based on both their biology and their gender. Women also experience poverty in unique ways and ultimately act as the shock absorbers of poverty for others.[95] The intersection between poverty, GBV and the HIV/AIDS epidemic further illustrates that women's particular needs and experiences need to be taken into account.[96] An interrelated approach is further supported by the Court's recognition of the integral role of these rights in facilitating the foundational value of equality in *Grootboom*:

> "There can be no doubt that human dignity, freedom and equality, the foundational values of our society, are denied those who have no food, clothing or shelter…The realisation of these rights is also key to the advancement of race and gender equality and the evolution of a society in which men and women are equally able to achieve their full potential." [97]

Through an overview of the relevant socio-economic jurisprudence I will now analyse the potential of substantive equality to develop a more gendered analysis of the impact of poverty.

2 4 2 *Soobramoney v Minister of Health, KwaZulu-Natal*

[93] De Vos (2001) *SAJHR* 261; Liebenberg & Goldblatt (2007) *SAJHR* 355.
[94] Bilchitz *Poverty and Fundamental Rights* 170 170–176.
[95] D M Chirwa & S Khoza "Towards Enhanced Citizenship and Poverty Eradication: A Critique of *Grootboom* from a Gender Perspective" in A Gouws (ed) *(Un)thinking Citizenship: Feminist Debates in Contemporary South Africa* (2005) 137 210.
[96] Brodsky & Day (2005) *AJ* 162.
[97] *Government of the Republic of South Africa v Grootboom* 2001 1 SA 46 (CC); 2000 11 BCLR 1169 (CC) para 23.

The first case in which the Court had to decide the justiciablity of the socio-economic rights was *Soobramoney v Minister of Health, KwaZulu-Natal* [98] (hereafter "*Soobramoney*") The applicant (a 41 year old man suffering from renal failure, heart disease and diabetes) approached a State hospital to procure the necessary ongoing dialysis treatment he required. The hospital refused his admission due to his pre-existing heart disease. Following the dismissal of an urgent application in the High Court (for an order requiring the hospital to admit him to the programme) the applicant appealed to the Constitutional Court basing his claim on the right to emergency medical treatment (section 27(3)) and the right to life in section 11.

The claim was dismissed with the Court finding that the applicant had no cause of action under sections 11 and 27(3) of the Constitution. The Court also held that the government's failure to allocate additional resources to renal dialysis programmes was not in breach of its section 27(1) and (2) obligations. The limitation of available resources[99] was specifically referred to in limiting access to health care services and consequently in limiting social transformation. This was in spite of the Court's recognition, that unless the social and economic inequalities in our society are addressed, the constitutional guarantees to equality, human dignity and freedom will have a 'hollow ring.'[100]

Within a developing country such as South Africa it needs to be recognised that there are resource constraints, and that most life-saving health care services are expensive. However, the commitment to a society based on the achievement of equality,[101] non-sexism and non-racism,[102] in addition to the extent of inequality within the health sector creates a moral and a legal justification for reasonable and transparent investments in the public health care system. The inclusion of the justiciable right to have access to

[98] 1998 1 SA 765 (CC), 1997 12 BCLR 1696 (CC).
[99] See *Soobramoney v Minister of Health, KwaZulu-Natal* 1998 1 SA 765 (CC); 1997 12 BCLR 1696 (CC) para 11, where Chaskalson P stated the following:
"What is apparent from these provisions is that the obligations imposed on the state by sections 26 and 27 in regard to access to housing, health care, food, water and social security are dependent upon the resources available for such purposes."
[100] *Soobramoney v Minister of Health, KwaZulu-Natal* 1998 1 SA 765 (CC); 1997 12 BCLR 1696 (CC) para 8.
[101] Section 1(a) of the Constitution.
[102] Section 1(b) of the Constitution.

health care services also limits the degree to which inequality between public and private health care services is constitutionally justifiable.[103]

In this case the Court could have discussed and developed the normative and interrelated nature of the right of everyone to have access to health care services before simply limiting the right on the basis of 'available resources.'[104] Chaskalson's statement that a court will be slow to interfere with rational decisions on the allocation of resources,[105] further revealed that the extent of these rights would be determined by those in positions of power, in contrast to interpreting the right according to human need, and the values and interests that the right is intended to protect. The vast inequality between the public and the private health sectors was passively acknowledged by the Court in *Soobramoney* as a hard and unpalatable fact:

> "The hard and unpalatable fact is that if the appellant were a wealthy man he would be able to procure such treatment from private sources; he is not and has to look to the state to provide him with the treatment. But the state's resources are limited and the appellant does not meet the criteria for admission to the renal dialysis programme."[106]

Such an arrangement is however the result of conscious social choices regarding the allocation of resources and the structuring of social institutions. As further pointed out by Amartya Sen:

---

[103] Liebenberg *Socio-Economic Rights* 145.

[104] *Soobramoney v Minister of Health, KwaZulu-Natal* 1998 1 SA 765 (CC); 1997 12 BCLR 1696 (CC) para 11. See: D Vos (2001) *SAJHR* 265; Pieterse (2009) *SAJHR* 217; Pieterse (2008) *SALJ* 555; Liebenberg *Socio-economic Rights* 143, where she discusses the possible interdependence between the right to life and the right to have access to health care services:

> "This interdependence could have developed in *Soobramoney* through a more substantive analysis of the role of the right to life and its underlying values in the interpretation of the health care rights entrenched in s 27."

[105] *Soobramoney v Minister of Health, KwaZulu-Natal* 1998 1 SA 765 (CC); 1997 12 BCLR 1696 (CC) para 29.

[106] *Soobramoney v Minister of Health, KwaZulu-Natal* 1998 1 SA 765 (CC); 1997 12 BCLR 1696 (CC) para 31.

> "Resources are fungible, and social arrangements can facilitate health of the deprived, not just at the cost of other people's health care or health achievement, but also through a different social arrangement or an altered allocation of resources."[107]

While absolute equality in access to health care services is clearly an ideal, the Court could have conducted a more proactive inquiry into whether health policies adhered to human rights standards or, at the very least, incorporated human rights considerations into decision making processes. In contrast the Court's passive acceptance of unavailable resources effectively de-politicised the resource allocation choices that were made.[108] This allows such choices to appear neutral and acceptable without considering whether such decisions have been made with the necessary consideration and respect for the justiciable rights in the Constitution. For example, the rights to equality (section 9), human dignity (section 10), life (section 11) and the right to have access to health care services (section 27(1)(a)) should play a role in future decisions concerning the allocation of resources to the public health care system. The formulation of the right, that 'everyone' is entitled to have access to health care services further justifies a consideration of the right to equality.

The Court could have also played a greater role in encouraging interrogation into the social construction of the health care system and the importance of redistributive and transformative steps in dismantling such inequality. An interrelated interpretation may therefore have encouraged a more robust analysis of how government intends on transforming such inequality, in light of our Constitution's transformative aspirations and the impact of inadequate health care policies on other fundamental human rights.

In contrast to the approach adopted in *Soobramoney*, the Court was able to conduct a more critical analysis in *Law Society of South Africa and Others v Minister for Transport and Another.*[109] In this case, the Court critically analysed the impact of the amendments to the Road Accident Fund Act 56 of 1996 (hereafter "the Act") on the ability to access health care services. The Court analysed the tariffs paid to road accident victims in terms of regulation 5 and section 17 (4B)(a) of the Act and ruled that the tariffs were so low that

[107] A Sen "Why Health Equity?" (2002) 11 *Health Econ* 659 662.
[108] M Pieterse "Health Care Rights, Resources and Rationing" (2007) 124 *SALJ* 514 516.
[109] 2011 1 SA 400 (CC).

road accident victims who cannot afford private medical treatment would be forced to utilise public health services.[110] The Court was able to scrutinise the impact of this, by recognising that this would in effect condemn certain road accident victims, and particularly those who are rendered quadriplegic or paraplegic, to die as such inadequate care would inevitably lead to their demise.[111]

The Court was also able to scrutinise the financial implications of the tariff, and pointed out that the negligible savings that the tariff would provide (approximately 6 %) did not reasonably justify possibly condemning quadriplegics or paraplegics to die due to inadequate public health care.[112] The Court therefore found these provisions in breach of section 27(1) (a) read together with section 27(2) of the Constitution.[113]

2 4 3 *Government of the Republic of South Africa v Grootboom*

Shortly after *Soobramoney* the Court developed reasonableness review even further in *Grootboom.*[114] In this case a destitute group of adults and children had moved onto private land from an informal settlement that had forced them to live in appalling conditions. Shortly after moving onto the private land they were brutally evicted. The case focused on the extent of the States' positive duties in relation to housing under section 26 of the Constitution. The Court reaffirmed the justiciability of the socio-economic rights, in addition to the constitutional duty of the courts to protect and fulfil these rights.[115] Ultimately the Court found that the nationwide housing programme fell short of its constitutional obligations to the extent that it failed to recognise and provide

[110] *Law Society of South Africa and Others v Minister for Transport and Another* 2011 1 SA 400 (CC) para 91.
[111] *Law Society of South Africa and Others v Minister for Transport and Another* 2011 1 SA 400 (CC) paras 92- 94.
[112] *Law Society of South Africa and Others v Minister for Transport and Another* 2011 1 SA 400 (CC) para 98.
[113] *Law Society of South Africa and Others v Minister for Transport and Another* 2011 1 SA 400 (CC) para 100.
[114] *Government of the Republic of South Africa v Grootboom* 2001 1 SA 46 (CC); 2000 11 BCLR 1169 (CC).
[115] *Government of the Republic of South Africa v Grootboom* 2001 1 SA 46 (CC); 2000 11 BCLR 1169 (CC) para 83.

relief for those whose needs are most urgent, emphasising that the right to adequate housing had been included because "we value human beings as human beings." [116]

Despite the fact that *Grootboom* was a laudable and ground-breaking judgment, certain aspects of the Court's decision constrained the transformative potential of section 26. This can be illustrated in the Court's affirmation of the classic liberal conception of the public/private law divide. For example, the Court stated that the primary obligations imposed by section 28(1) (c) of the Constitution, which states that every child has the right to basic nutrition, shelter, basic health care services and social services, rests upon the parents.[117] The Court warned that a finding that this obligation rested on the State could create the danger of children being used as stepping stones by their parents to gain access to housing.[118] The Court also held that children have the right to parental care first, and only have a right to have access to alternative care when parental care is lacking.[119]

The public/private law divide[120] is based on the perception that the domestic sphere and the market place comprise the private sphere, where theoretically free and autonomous individuals interact.[121] As the private sphere is where sexuality, reproduction and family life reside,[122] women have been associated with the private sphere. In contrast, the public sphere is associated with activities such as politics and law, which have traditionally been dominated by men. This divide led to the preoccupation that individuals only needed to be protected from the abuse of public power. Consequently the harms suffered by women within the private sphere were relegated to a lower social

[116] *Government of the Republic of South Africa v Grootboom* 2001 1 SA 46 (CC); 2000 11 BCLR 1169 (CC) para 44.
[117] *Government of the Republic of South Africa v Grootboom* 2001 1 SA 46 (CC); 2000 11 BCLR 1169 (CC) para 77. See: Liebenberg *Socio-economic Rights* 241.
[118] *Government of the Republic of South Africa v Grootboom* 2001 1 SA 46 (CC); 2000 11 BCLR 1169 (CC) para 71.
[119] *Government of the Republic of South Africa v Grootboom* 2001 1 SA 46 (CC); 2000 11 BCLR 1169 (CC) para 77
[120] Susan Boyd refers to the public/private divide as a shifting ideological marker that refers to identifiable relations of power. These imbalances of power, such as those based on race, class and gender, need to be understood and addressed, which necessarily requires the deconstruction of this divide. See: S B Boyd "Introduction: Challenging the Public/Private Law Divide" in S B Boyd (ed) *Challenging the Public/Private Law Divide: Feminism, Law and Public Policy* (1997) 1 4.
[121] Liebenberg *Socio-Economic Rights* 59.
[122] E Bonthuys "The Personal and the Judicial: Sex, Gender and Impartiality" (2008) 24 *SAJHR* 239 240

ranking.[123] This divide, which is prevalent within legal institutions, doctrines and rules, therefore constrains the ability of the legal system to respond to abuse within the private sphere, such as GBV.[124]

This affirmation by the Court therefore effectively entrenched a limited perception of the State's duty to intervene within the private sphere when human rights are violated. This is a dangerous line of reasoning as individuals within the private sphere are just as capable of limiting access to socio-economic resources as the State is. A true commitment to the achievement of gender equality and socio-economic equality, therefore necessarily entails a rejection of some of the key assumptions of traditional liberal legalism.[125] Section 8(2) of the Constitution also states that the Constitution binds both natural and juristic persons, which provides further constitutional justification for transcending this divide.[126]

An interrelated interpretation of the right to have access to housing and the right to equality may have further assisted in ensuring that government policies and programmes uplift all groups equally.[127] For example, the fact that the majority of the Grootboom community was made up of women and children could have been recognised by the Court. Recognition of the particular needs of different groups is further necessary as the poor are not one homogenous group. In this regard, many public law instruments on housing have been criticised for only providing the basic minima in relation to housing, and thus neglecting the specific needs and experiences of different groups, such as women.[128] While the housing needs of survivors of domestic violence were not raised within the application, the reality of GBV and its impact upon access to housing for women could perhaps have been addressed by the amicus curiae in this case. For example, property is often registered in the name of the man in a relationship, which in

[123] N Fraser "From Redistribution to Recognition: Dilemmas of Justice in a "Post-socialist" Age?" in *Justice Interruptus: Critical Reflections on the Post-Socialist Condition* (1997) 11 20.
[124] R Copelon "Recognizing the Egregious in the Everyday: Domestic Violence as Torture" (1994) 25 *Columbia Human Rights Law Review* 291 292.
[125] Albertyn & Goldblatt (1998) *SAJHR* 251.
[126] Liebenberg *Socio-economic Rights* 327.
[127] Liebenberg & Goldblatt (2007) *SAJHR* 351.
[128] L Chenwi & K McLean "A Woman's Home is her Castle? - Poor Women and Housing Inadequacy in South Africa" (2009) 25 *SAJHR* 517 518.

combination with the housing crisis in South Africa forces many women to remain in abusive relationships.[129]

The contextual analysis within the unfair discrimination test could therefore have enriched this case through its recognition of the systemic nature of discrimination. An equality perspective could have further highlighted the need for provisions that are tailored to the specific needs of different groups. A deeper consideration of equality and a more nuanced approach to disadvantage could therefore have broadened the normative framework applicable to national housing policies and programmes.[130]

2 4 4 *Minister of Health v Treatment Action Campaign*

In 2001 the Treatment Action Campaign launched a constitutional claim against the Minister of Health,[131] which culminated in the Constitutional Court Case of *Minister of Health v Treatment Action Campaign* (hereafter "*Treatment Action Campaign*").[132] The claim was based on the government's limited provision of the anti-retroviral drug (nevirapine) to particular research and training sites, despite its proven effectiveness in reducing intrapartum mother-to-child transmission of the HIV/AIDS virus. The High Court found that "government had acted unreasonably in (a) refusing to make nevirapine available in the public health sector… and (b) not setting out a timeframe for a national programme to prevent mother-to-child transmission of HIV."[133] The Constitutional Court confirmed this, stating that the State's limited and inflexible programme did not comply with its obligations under sections 27(1) and 27(2),[134] and made both declaratory and mandatory orders against the government. While socio-economic jurisprudence may not

---

[129] Chenwi & McLean (2009) *SAJHR* 532.

[130] This was briefly touched upon by Justice Yacoob in paragraph 23 of the *Government of the Republic of South Africa v Grootboom* 2001 1 SA 46 (CC); 2000 11 BCLR 1169 (CC) judgment:

> "Our Constitution entrenches both civil and political rights and social and economic rights. All the rights in our Bill of Rights are inter-related and mutually supporting."

However, this aspect could have been developed further given the composition of the *Grootboom* community.

[131] *Treatment Action Campaign v MEC for Health, Mpumalanga and Minister of Health* Case No 35272/02 (TPD).

[132] *Minister of Health and Others v Treatment Action Campaign and Others* (No 2) 2002 5 SA 721 (CC); 2002 10 BCLR 1033 (CC).

[133] *Minister of Health v Treatment Action Campaign* (No 2) 2002 5 SA 721 (CC) para 2.

[134] Liebenberg *Socio-Economic Rights* 147-148.

always have positive social outcomes that can be effectively measured *Treatment Action Campaign* had a discernible positive impact. The Court pointed out that:

> "The government has made substantial additional funds available for the treatment of HIV, including the reduction of mother-to-child transmission. The total budget to be spent ...has been increased to R1 billion in the current financial year and will go up to R1,8 billion in 2004/5."[135]

This revealed that if the requisite political will is present, socio-economic services can be expanded and improved, which also raises the need to proactively question the reactionary defence of unavailable resources within socio-economic jurisprudence.[136] Despite these positive social consequences, it is submitted that the Court could have developed a broader understanding of a more gender-sensitive and transformative approach to the right of access to health care services, including reproductive health care. Such an approach would have been further justified by the gendered nature of the HIV/AIDS epidemic.

Ultimately the case was considered based on the right to have access to health care services within the context of pregnancy and motherhood.[137] The Court specifically stated that consideration needed to be given to the fact that the case concerned the lives of new-born babies who might be saved by the administration of nevirapine to mother and child at the time of birth.[138]

While the particularly important interests that were at stake resulted in a more substantive standard of reasonableness review, the interests of the HIV positive pregnant women were insufficiently relied upon as the substantive basis for the extension of nevirapine. This perpetuated the traditional approach that the health care needs of

---

[135] *Minister of Health v Treatment Action Campaign* (No 2) 2002 5 SA 721 (CC) para 120.
[136] *Minister of Health v Treatment Action Campaign* (No 2) 2002 5 SA 721 (CC) para 119.
[137] Albertyn (2012) *Stell LR* 604. The Court also specifically stated that:
"At issue here is the right given to everyone to have access to public health care services and the right of children to be afforded special protection." *Minister of Health v Treatment Action Campaign* (No 2) 2002 5 SA 721 (CC) para 4.
[138] *Minister of Health v Treatment Action Campaign* (No 2) 2002 5 SA 721 (CC) para 72.

women become secondary as their role as mothers and caregivers takes priority.[139] Such an approach consequently fails to foster substantive gender equality and only contributes to the invisibility of women's broader health care needs.

An equality analysis within this case could have contributed to an interpretation of section 27 which is more responsive to systemic gender-based discrimination. In this regard the amicus curiae could have put arguments before the Court that highlighted how GBV has compounded the HIV/AIDS epidemic. For example, historic gender-based discrimination has diminished the chances of taking HIV/AIDS preventative measures. It has also reduced women's willingness to disclose their HIV/AIDS status (due to a fear of violence) and of accessing anti-retrovirals (as many women are coerced into sharing such medication).[140] The right to equality and the right to have access to health care services could therefore have been used to highlight the mutually reinforcing patterns of poverty and gender inequality in relation to the HIV/AIDS epidemic. An interrelated approach could furthermore have been utilised to advance women's particular health care needs, in light of past gender discrimination. This in turn could have provided greater normative guidance to government in formulating gender-sensitive health care policies in future.

It needs to be recognised that the *Treatment Action Campaign* case was approached from a strategic position which feared that the 'choice' argument would be used against the applicants.[141] This reveals the strategic challenges facing amicus curiae in public interest litigation, while also revealing their particular responsibility in such cases. This case therefore illustrates that the social and political context of litigation cannot be divorced from legal strategies. However, this case further highlights the need for more gender-sensitive arguments and perspectives on interpretations of the right to health care in order to 'engender' the normative framework that shapes health care policies and programmes, particularly in relation to HIV/AIDS programmes.

---

[139] Albertyn (2012) *Stell LR* 603.
[140] M Mushariwa "The Right to Reproductive Health and Access to Health Care Services within the Prevention of Mother-to-child Transmission Programme: The Reality on the Ground in the Face of HIV/AIDS" in B Goldblatt & K McLean (eds) *Women's Social and Economic Rights* 183 187.
[141] Albertyn (2012) *Stell LR* 604.

2 4 5 *Khosa and Others v Minister of Social Development and Others*

Khosa and Others v Minister of Social Development and Others, [142](hereafter "*Khosa*") is a prime example of how the right to equality can be used to reinforce the socio-economic rights. In this case the Court dealt with the extension of social security benefits to permanent residents (who were completely excluded from the social security system) and explicitly recognised the integral role of equality in constitutional adjudication:

> "Equality is also a foundational value of the Constitution and informs constitutional adjudication in the same way as life and dignity do. Equality in respect of access to socio-economic rights is implicit in the reference to "everyone" being entitled to have access to such rights in section 27."[143]

When considering unfair discrimination the Court recognised the economic hardship that permanent residents faced. In examining the reasonableness of excluding permanent residents from social security programmes the Court considered the purpose served by social security, the impact of the exclusion on permanent residents, and the relevance of the citizenship requirements to that purpose. In this case the Court was able to recognise that decisions on how to allocate public resources illustrated the extent to which: "poor people are treated as equal members of society."[144] The interrelationship between the right to be protected from unfair discrimination and the right to social security thus resulted in a more stringent application of the reasonableness review standard.

The value of an interrelated interpretation is further revealed in the Court's intensive evidence-based scrutiny of the government's budgetary decisions in this regard.[145] This is in contrast to the passive approach pursued in *Soobramoney.* This approach therefore

---

[142] *Khosa and others v Minister of Social Development; Mahlaule v Minister of Social Development* 2004 6 SA 505 (CC); 2004 6 BCLR 569 (CC).
[143] *Khosa and others v Minister of Social Development and Others* 2004 6 SA 505 (CC); 2004 6 BCLR 569 (CC) para 42.
[144] *Khosa and others v Minister of Social Development and Others* 2004 6 SA 505 (CC); 2004 6 BCLR 569 (CC) para 74.
[145] *Khosa and others v Minister of Social Development and Others* 2004 6 SA 505 (CC); 2004 6 BCLR 569 (CC) para 62.

allowed for the extension of social security benefits to a particularly vulnerable group within our society. Such an approach could be utilised in future health related cases, allowing the Court to openly scrutinise the defence of 'a lack of available resources' when determining the extent to which the health needs of women have been considered on a basis of equality.

2 4 6 *Mazibuko and Others v City of Johannesburg and Others*

In *Mazibuko and Others v City of Johannesburg and Others*[146] (hereafter "*Mazibuko*") the Court dealt with the proper interpretation of section 27(1) (b) of the Constitution which provides that everyone has the right to have access to sufficient water. In 2001 the City of Johannesburg and Johannesburg Water (Pty) Ltd agreed to provide every household within the City with 6 kilolitres of free water per month per household/account holder. In terms of the pre-payment system (which was implemented in 2004) once the 6 kilolitres have been consumed, the water supply to the stand is automatically cut off. This differs considerably from the process followed within richer areas, which includes notification before the water is cut off. Given the integral nature of water for almost all daily activities, this unequal treatment effectively compounds the suffering of the poor.

The central issue that was considered within this case was the reasonableness of the provision by the City of Johannesburg of providing 25 litres per person per day. The case also concerned whether the installation of the pre-paid water meters in Phiri under the Water Services Act and the City's Water Services By-laws was administratively unfair, and whether it was unfairly discriminatory under section 9 of the Constitution.

Despite the fact that the High Court judgment has been heralded as ground-breaking for its sensitivity to the lived reality of the poor, the Constitutional Court's judgment was particularly disappointing. While the High Court recognised the patriarchal nature of South African society, in addition to the burden of care that many women experience,[147]

[146] 2010 3 BCLR 239 (CC); 2010 4 SA 1 (CC).

[147] In *Mazibuko v City of Johannesburg (Centre on Housing Rights and Evictions as Amicus Curiae)* [2008] 4 All SA 471 (W) para 159 the court recognised that:

"South Africa is a patriarchal society. Many domestic chores are performed by women. Many households in poor black areas are headed by women. Phiri Township is no exception. It is

the Constitutional Court failed to develop this line of reasoning. The High Court was further able to link how inadequate access to water entrenches and exacerbates gender inequality. Evidence was presented to the court which revealed that the 25 litres per person per day was insufficient due to the fact that it takes 10-12 litres to flush a toilet in water borne sanitation areas, the average number of persons on a stand is 16 and most of the people living in Phiri are poor, uneducated and ravaged by HIV/AIDS.[148] The hot and dry climate of Soweto was also highlighted, in addition to the fact that because the residents were living in an urban area it was even more difficult to access water from rivers and streams.[149] The court also referred to the evidence of Desmond James Martin, the President of the Southern African HIV Clinicians Society who provided the following contextual analysis of the lack of adequate water on women:

> "In general terms in South Africa women carry a disproportionate HIV related burden. This is because women are more susceptible to HIV infection, more vulnerable to sexual pressure and they are often the primary caregivers to PLWHA [people living with HIV/AIDS]. Five of the seven applicants in this case are women representing female headed households. One of these women, Grace Munyai, was a caregiver to her HIV infected niece. As testified in Mrs Munyai's affidavit, the additional water required to take care of her HIV infected niece, Sizile, necessitated a 3km walk to fetch water as the free basic amount was insufficient to ensure hygienic conditions and adequate drinking water. Given the gendered nature of the HIV pandemic it is particularly important for women's health, standard of living, equality and dignity to have access to sufficient water."[150]

---

understandable therefore that the first applicant travelled 3 kilometers to access water on behalf of her household. In this context it seems to me that the prepayment meters discriminate against women unfairly because of their sex. Discrimination on the basis of sex is outlawed. It is unconstitutional and unlawful."

[148] *Mazibuko v City of Johannesburg (Centre on Housing Rights and Evictions as Amicus Curiae)* [2008] 4 All SA 471 (W) para 169.

[149] *Mazibuko v City of Johannesburg (Centre on Housing Rights and Evictions as Amicus Curiae)* [2008] 4 All SA 471 (W) para 171.

[150] *Mazibuko v City of Johannesburg (Centre on Housing Rights and Evictions as Amicus Curiae)* [2008] 4 All SA 471 (W) para 172.

While the Constitutional Court recognised the integral nature of water,[151] in addition to the importance of equal access to water for all,[152] the Court neglected to address the integral nature of water in relation to the gendered nature of the HIV/AIDS epidemic. In addition, despite the recognition that millions of people and specifically women, spend copious amounts of time collecting their water from alternative sources,[153] the Constitutional Court failed to address this reality in a manner that provided substantive content to the rights to equality and the right to have access to sufficient water.

In relation to the Court's consideration of unfair discrimination, its analysis of impact and context was unduly limited. The Court simply compared the current policy to the previous flat rate policy whilst ignoring the very real disadvantage that the current policy caused. The Court then focused disproportionately on the nature and purpose of the government policy considerations in the conservation of water,[154] stating that even though the group affected was in fact a vulnerable group, the purpose of the meters was laudable and necessary.[155] This resulted in the Court finding that while the water policy resulted in discrimination, it did not result in unfair discrimination. This approach by the Court was noteworthy for neglecting to recognise the detrimental impact of insufficient water on the daily lives of the applicants, and the very real manner in which it compounds disadvantage for poor women.[156]

---

[151] *Mazibuko and Others v City of Johannesburg and Others* 2010 3 BCLR 239 (CC); 2010 4 SA 1 (CC) Justice O'Regan held in para 1 that:

> "Water is life...Human beings need water to drink, to cook, to wash and to grow our food." Despite the fact that these are activities which predominantly affect women concerned with domestic responsibilities, the Court failed to consider the gendered implications of inadequate access to such water.

[152] *Mazibuko and Others v City of Johannesburg and Others* 2010 3 BCLR 239 (CC); 2010 4 SA 1 (CC) para 2

[153] *Mazibuko and Others v City of Johannesburg and Others* 2010 3 BCLR 239 (CC); 2010 4 SA 1 (CC) para 2.

[154] *Mazibuko and Others v City of Johannesburg and Others* 2010 3 BCLR 239 (CC); 2010 4 SA 1 (CC) paras 152-153.

[155] *Mazibuko and Others v City of Johannesburg and Others* 2010 3 BCLR 239 (CC); 2010 4 SA 1 (CC) para 154. See: Albertyn (2012) *Stell LR* 608.

[156] Dugard & Mohlakoana (2009) *SAJHR* 547:

> "Inadequate access to water and electricity services has a disproportionately negative effect on women. This is because, as explored in other articles in this issue, there is a sexual division of labour within most households meaning that women are 'often singly responsible for child-care, cleaning the house, fetching and heating water, washing and ironing, shopping, collecting firewood, cooking and washing dishes."

This revealed the dangerous potential for an imbalanced approach within reasonableness review, in that the focus remained predominantly on the State's justifications and reasons for failing to fulfil their constitutional obligations in terms of section 27(2) of the Constitution. In contrast, the Court should have provided a more robust consideration of the values and interests that section 27(1) of the Constitution is intended to protect. The experiences of the vulnerable groups that bear the brunt of this deprivation and how the State can proactively combat this hardship was further neglected. The Court's approach therefore prevented the development of a gendered understanding of the right to have access to water.

2 4 7 Interpreting reasonableness review to incorporate the interdependence of socio-economic rights and gender equality

GBV and women's poverty go to the core of women's subordination in society. It is therefore necessary to explore the bounds of reasonableness review in light of this reality. The Court's emphasis on social and historical context[157] arguably provides room for a particularly gendered approach to such context. Broadly then, unification between substantive equality and socio-economic jurisprudence allows for the four overarching aspects of substantive equality, which includes attention to context, impact, positive recognition of difference and transformative values to be integrated into reasonableness review.[158] An interrelated interpretation would thus allow reasonableness review to incorporate the following inquiries:

(i) Attention to context would allow the Court to consider the historical and current social context within which the claimant group is situated. This would reveal that different groups have different needs while highlighting the intersecting nature of different axes of disadvantage. This would facilitate an examination of the true extent of an alleged rights violation in relation to systemic forms of domination within our society. Attention to social context further highlights the need for remedial programmes that target the specific

[157] *Government of the Republic of South Africa v Grootboom* 2001 1 SA 46 (CC); 2000 11 BCLR 1169 (CC) para 22.
[158] Albertyn (2012) *SLR* 16; S Fredman "Engendering Socio-Economic Rights" (2009) 25 *SAJHR* 410 411.

needs and experiences of women. This would assist the State in developing more effective and responsive programmes for women.[159] The following statement by Justice Kate O 'Regan in *Hugo*[160] highlights the importance of a realistic assessment of the group's vulnerability in unfair discrimination cases:

> "The more vulnerable the group adversely affected by the discrimination, the more likely the discrimination will be held to be unfair. Similarly, the more invasive the nature of the discrimination upon the interests of the individuals affected by the discrimination, the more likely it will be held to be unfair."[161]

(ii) Sufficient recognition should be given to the impact of the denial of access to the relevant socio-economic resource or service on particular groups.[162] Part of this enquiry should include whether the State conduct/omission prevents the claimant groups from developing to their full human potential on a basis of equality. A further enquiry is whether the State conduct/omission entrenches or perpetuates systemic patterns of inequality within our society. For example, a relevant factor that could have informed the reasonableness inquiry in *Treatment Action Campaign* was the impact of the State's omission to provide adequate health care services to women, on the constitutional goal of achieving racial and gender equality.[163] Given the gendered nature of the HIV/AIDS epidemic, an interrelated approach may have further exposed the devastating impact of failing to provide nevirapine to HIV-positive pregnant women.

(iii) In substantive equality, the positive recognition of difference seeks to recognise diversity while transforming the disadvantage that often attaches to it. This social recognition is imperative in order to transform underlying power imbalances between groups. This recognition further requires that negative stereotypes are not inadvertently reinforced. When determining whether a government programme is able to facilitate the

[159] Liebenberg &Goldblatt (2007) *SAJHR* 351.
[160] 1997 4 SA 1 (CC); 1997 6 BCLR (CC).
[161] *President of the Republic of South Africa v Hugo* 1997 4 SA 1 (CC); 1997 6 BCLR (CC) para 112.
[162] Liebenberg & Goldblatt (2007) *SAJHR* 357.
[163] Liebenberg & Goldblatt (2007) *SAJHR* 339.

realisation of a socio-economic right,[164] an interrelated interpretation would therefore broaden this consideration to whether the programme is able to facilitate the transformation of negative gendered stereotypes.[165] For example, in *Treatment Action Campaign*, health care policies governing the provision of nevirapine could have been analysed for their responsiveness to gender inequality and GBV, in contrast to inadvertently entrenching the predominate focus on women as mothers.

(iv) Sensitivity to a value based approach would facilitate a more robust enquiry as to whether a policy fosters the constitutional values of human dignity, equality and freedom.[166] A key factor in reasonableness review is the nature of the service or resource in question. The values underlying section 9 could enrich the consideration of the importance of a socio-economic good, in light of its redistributive and transformative potential. For example, the integral role of post-exposure prophylaxis[167] (hereafter "PEP") in preventing HIV/AIDS infection, while protecting and enhancing the dignity and freedom of women should play a role in the evaluation of health care policies on its administration.

In this manner the underlying values and goals of substantive equality would be able to stimulate the contextual nature of reasonableness review to be more sensitive to the systemic nature of inequality. This would facilitate a more humane approach focused on the context and the particulars of a moral problem, rather than simply applying universal rules without connecting to the daily suffering of specific groups.[168]

2 4 8 Implications of an interrelated interpretation

[164] *Government of the Republic of South Africa v Grootboom* 2001 1 SA 46 (CC); 2000 11 BCLR 1169 (CC) para 41.
[165] Albertyn (2012) *Stell LR* 601.
[166] Albertyn (2012) *Stell LR* 605.
[167] According to the World Health Organisation Post Exposure Prophylaxis refers to:
"The set of services that are provided to manage the specific aspects of exposure to HIV and to help prevent HIV infection in a person exposed to the risk of getting infected by HIV. These services might comprise first aid, counselling including the assessment of risk of exposure to the infection, HIV testing, and depending on the outcome of the exposure assessment, the prescription of a 28-day course of antiretroviral drugs, with appropriate support and follow-up." See:
World Health Organisation & International Labour Organisation "Post-exposure Prophylaxis to Prevent HIV Infection: Joint WHO/ILO Guidelines on Post-exposure Prophylaxis (PEP)." (2007)1 9 <http://whqlibdoc.who.int/publications/2007/9789241596374_eng.pdf> (accessed 14-03-2011).
[168] J Nedelsky "Embodied Diversity and Challenges to Law" (1997) 42 *McGill Law Journal* 91 99.

Infusing health care services with equality considerations would be valuable as it would highlight the broader specific health care needs of women. This would be in contrast to simply adopting the 'women as mothers' approach. An interrelated approach could further expose the underlying social causes of women's ill-health. This could then be used to broaden the normative framework of health care programmes and policies addressing women's health care needs. An interrelated approach further highlights the State's commitment to addressing gender inequality by effectively analysing the allocation of State resources to women's particular health care needs through a gender lens.

The commitment to a society based on the achievement of equality,[169] non-sexism and non-racism,[170] in addition to the right to be free from unfair discrimination on the grounds of gender (section 9(3)) provides additional justification for a more robust scrutiny by the judiciary of the allocation of health care resources by the State. It also justifies an engendered analysis of the extent to which such rights have been given effect through legislation and policy. Such an interpretative approach would (at least initially) then redirect the focus from the State's justifications for limiting the right (on the limitation of available resources), to the impact of inadequate health care services on the lived reality of abused women.

A more interrelated approach may also be used to hold the government accountable for failing to address specific forms of GBV, such as domestic violence[171] and human trafficking in health care policies. The positive obligations imposed upon the State in terms of the socio-economic rights can also be better utilised if they are seen as interconnected to the positive obligation to prevent GBV [172] (and therefore gender discrimination).

---

[169] Section 1(a) of the Constitution.
[170] Section 1(b) of the Constitution.
[171] S Mathews & N Abrahams (The Gender Advocacy Programme & The Medical Research Council & Gender & Health Research Group) "Combining Stories and Numbers: An Analysis of the Impact of the Domestic Violence Act (No.116 of 1998) on Women" (2001) 1-34 2 <. http://www.mrc.ac.za/gender/domesticviolence.pdf> (accessed 14-02-2011).
[172] *Carmichele v Minister of Safety and Security and Another* 2001 4 938 (CC): 2001 10 BCLR 995 (CC) para 62.

The duty to protect women from all forms of violence,[173] read in conjunction with the obligation to progressively realise section 27(1) (a) could further support section 9(2)'s redistributive measures. For example, an interrelated approach could be used to justify the extension of current health care programmes to address additional forms of violence. For example, in contrast to primarily focusing on sexual violence, health care policies could be developed to address domestic violence and human trafficking. This is further justified by the epidemic levels of domestic violence that currently plague South Africa.[174]

An interrelated approach could furthermore be explored as the potential basis for a claim for the extension of the nature of the current services provided. Currently, the psychological health care needs of survivors of rape and domestic violence are neglected.[175] In this context, an interrelated approach could bolster a claim for access to counselling for post-traumatic stress disorder and depression, while barriers preventing access to PEP could also be challenged.

Finally, an interrelated approach could require that health care services be tailored to the specific needs of survivors of GBV.[176] For example, in the Canadian court case of *Eldridge v Attorney General of British Columbia,*[177] the Court held that substantive equality required that the provincial government provide sign language interpreters for deaf patients. In the British case of *Yemshaw v London Borough of Hounslow*[178] the Supreme Court broadened the recognition of domestic violence in relation to access to housing. The Court recognised that domestic violence comprises more than physical violence, and that non-physical violence can be devastating in and of itself. The British Supreme Court therefore held that when deciding whether a person would reasonably be

[173] *Carmichele v Minister of Safety and Security and Another* 2001 4 938 (CC): 2001 10 BCLR 995 (CC) para 62.
[174] S Mathews, N Abrahams, LJ Martin , L Vetton, L Van der Merwe & R Jewkes "Every Six Hours a Woman is Killed by Her Intimate Partner" (2004) 5 *MRC Policy Brief* 1 1 <http://www.mrc.ac.za/policybriefs/woman.pdf> (accessed 15-02-2011).
[175] While the National Guidelines for Sexual Assault Care released by the Department of Health provides for counselling, government has been criticised for the lack of implementation and inadequate training of staff. See: National Department of Health Guidelines for Managing HIV in the Context of Sexual Assault" (2007) 1-80 <http://pdf.usaid.gov/pdf_docs/PNADT749.pdf> (accessed 12-03-2011); United Nations Agency International Development South Africa "Final Report on the Compliance Assessment of the Thuthuzela Care Centres with National Department of Health Guidelines for Managing HIV in the Context of Sexual Assault" (2007) 1 5-6 <http://pdf.usaid.gov/pdf_docs/PNADT749.pdf> (accessed 12-03-2011).
[176] Liebenberg & Goldblatt (2007) *SAJHR* 350.
[177] (1997) 151 DLR (4th) 577 (SCC).
[178] [2011] UKSC 3.

expected to remain in her current accommodation one must take account of the seriousness of non-physical domestic violence, such as intimidation and denial of freedom and the denial of financial support for essentials.[179] Even though this case is related to housing, it highlights the possibility of engendering the interpretation of socio-economic services, such as health care services to be more responsive to the needs of women, and particularly women subjected to domestic violence. It further highlights that courts are able to develop the law to be more consonant with the lived reality of women. An engendered analysis of the right to have access to health care services could therefore facilitate a shift towards more holistic and responsive health care programmes for women by the State.

2 5 Conclusion

Deciding whether a case should be argued on the basis of equality or on the basis of the right to have access to health care services, or whether an interrelated interpretation of the two rights is required, is a strategic decision that will depend on the facts and the nature of the case. However, the intersecting nature of gender inequality and the feminisation of socio-economic burdens clearly necessitate a mutually reinforcing relationship between the socio-economic rights and the equality right.[180]

In relation to unfair discrimination cases, a deeper recognition of how material disadvantage compounds women's vulnerability to violence and exploitation would enrich considerations of unfair discrimination for female applicants. An interrelated approach is also able to transcend classic liberal conceptions of choice and a formal conception of equality. This would subsequently guard against the conflation between dignity and equality, while highlighting the need for redistributive and transformative steps in order to foster substantive gender equality.

---

[179] *Yemshaw v London Borough of* Hounslow [2011] UKSC 3 para 36:
"As the housing officers and review panel adopted a narrow view of domestic violence in this case, it is agreed that it must be remitted to the authority to be decided again."
[180] Albertyn (2007) *SAJHR* 257.

Conversely, infusing the right to have access to health care services with the values underpinning the right to equality may assist in transcending a purely legalistic perspective. [181] An interrelated approach may further serve to interrogate social processes and power relations and the more subtle ways in which such power can be abused to undermine the health of women. This can serve to broaden the normative content of the right to have access to health care services and accordingly assist the government in developing more gender-sensitive health care policies and programmes. In this regard an interrelated approach may assist in transforming gender-based disadvantage in South Africa, while highlighting forms of GBV that have traditionally been neglected by the public health care sector.

An interrelated interpretation therefore has the potential to increase judicial sensitivity to the various contexts within which socio-economic violations occur, and the various interests and values that are implicated. On a practical note, by infusing the right to have access to health care services (section 27) with the values and principles underlying substantive equality (section 9), an applicant may also broaden the issues, and the evidence that may be presented to the Court. An interrelated interpretation therefore allows for a deeper consideration of gender inequality within our society in addition to a more substantive interpretation of the constitutional rights.

What is therefore clear is that a gendered analysis of reasonableness review is possible, despite the invisibility of women in many of the socio-economic cases. What remains to be analysed is the responsiveness of our legislative and policy framework to the reality of GBV, in addition to the health care needs of survivors of such violence. This issue is addressed in the following chapter.

[181] B KirombaTwinomugisha “Beyond Juridical Approaches: What Role can the Gender Perspective Play in Interrogating the Right to Health in Africa” in F Viljoen (ed) *Beyond the Law: Multidisciplinary Perspectives on Human Rights* (2012) 41 51.

3 The legislative framework pertaining to health care for survivors of gender-based violence

3 1 Introduction

This chapter examines relevant legislative and policy interventions addressing the health care needs of survivors of gender-based violence (hereafter "GBV"). The National Health Act 61 of 2003, the Domestic Violence Act 116 of 1998 and the Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007, will therefore be analysed to reveal existing gaps, inconsistencies and shortcomings. Relevant health policy will also be analysed. This will be followed by an examination of the extent to which such provisions have been effectively implemented.

An analysis of the extent to which effective implementation has occurred is necessary as rights are only effective if people have access to the institutional support necessary to exercise such rights.[1] An overview of existing legislative provisions, in addition to the extent to which they have been implemented is also in line with the three processes identified by Nancy Fraser in the "politics of need interpretation".[2] The first process involves the political struggle for validation and recognition of specific needs. The second process entails efforts to define and interpret such needs. For example, how rights are interpreted and defined in legislation and policy. The final process involves the effective implementation of such defined needs.

In South Africa, great progress has been made since 1994, in attaining recognition of the specific needs of vulnerable groups, such as women and the poor.[3] For example, the first president of the newly democratic government, Nelson Mandela, pointed out that

[1] M Nussbaum "Capabilities as Fundamental Entitlements: Sen and Social Justice" (2003) 9 *Feminist Economics* 33 38.

[2] N Fraser "Talking about Needs: Interpretive Contests as Political Conflicts in Welfare-State Societies" (1989) 99 *Ethics* 291 294. See also: M Pieterse "Legislative and Executive Translation of the Right to Have Access to Health Care Services" (2010) 14 *Law, Democracy & Development* 1 1.

[3] For example, the Constitution of the Republic of South Africa, 1996 (hereafter "the Constitution") contains an extensive framework of progressive rights including the right to have access to health care services, section 27(1)(a), and the right to equality, section 9 (the constitutional framework is discussed in detail in chapter 2). See also: C Albertyn "Contesting Democracy: HIV/AIDS and the Achievement of Gender Equality in South Africa" (2003) 29 *Feminist Studies* 595 595.

South Africa would not be completely free until "women have been emancipated from all forms of oppression".[4] However, despite such a broad recognition of the importance of gender equality, GBV has reached epidemic levels in South Africa.[5] This chapter therefore analyses the responsiveness of health legislation and policy to the needs of women who have been subjected to GBV. It attempts to identify where there are shortcomings or gaps that fail to give adequate effect to the constitutional rights to which women are entitled. This analysis will be done within the general context of unequal access to quality health care services that exists in South Africa.

3 2 Challenges facing equal access to quality health care services in South Africa

Before the democratic elections of 1994, South Africa had a fragmented and racialist health care system that was predominantly urban-based and curative-orientated.[6] Centuries of colonialism and decades of apartheid rule thus resulted in race, geographic location and socio-economic status determining the quality of health care services that one received.[7] The private health sector contributed to this inequitable state of affairs. Medical aid schemes often charged exorbitant fees while effectively discriminating against the chronically ill, the elderly and the poor.[8] This legacy of apartheid continues to haunt the South African health care system of today. For example, the public health care system caters for the majority of the population, despite the fact that it is still severely under-resourced. The public health care system is also suffering from a severe shortage

[4] President Nelson Mandela "State of the Nation Address 1994" (1994) < http://www.sahistory.org.za/article/state-nation-address-president-south-africa-nelson-mandela> (accessed 12-03-2011).
[5] People Opposing Women Abuse "Criminal injustice: Violence against Women in South Africa" (2010) 1 7 <http://www2.ohchr.org/english/bodies/cedaw/docs/ngos/POWA_Others_SouthAfrica48.pdf> (accessed 21-02-2011).
[6] C Ngwena & R Cook "Rights Concerning Health" in D Brand & C H Heyns (eds) *Socio-Economic Rights in South Africa* (2005) 107 128.
[7] H Coovadia, R Jewkes, P Barron, D Sanders, D McIntyre "The Health and Health System of South Africa: Historical Roots of Current Public Health Challenges" (2009) 374 *The Lancet* 817 817-819.
[8] Ngwena & Cook "Rights Concerning Health" in *Socio-Economic Rights* 130.

of skilled medical personnel.[9] This has resulted in the public health care system delivering inadequate and low-quality health care services to the majority of the population.[10]

This dismal state of affairs is surprising, as South Africa spends a higher percentage of its gross domestic product (hereafter "GDP") on health care, than many other countries.[11] However, on closer analysis it is revealed that 4.1% of the GDP is spent on the private sector, while 4.2% is spent on the public health sector.[12] This difference is negligible, and is problematic given that the public health care system provides services for the majority (84%) of the South African public.[13] This imbalance is further illustrated in the fact that only 16% of the South African population is currently covered by medical aid schemes.[14] The majority of those who are not covered, and who are therefore unable to access quality health care services in the private sector are women, children, the elderly and low-income groups.[15]

Research conducted by the South African Human Rights Commission has further described the public health care system as 'lamentable'.[16] Problems facing the system include an inadequate infrastructure, limited or non-existent transport, long waiting hours and the discriminatory attitudes of overworked and desensitised staff members.[17] South Africa is also facing the quadruple burden of HIV/AIDS and TB, maternal, infant and child mortality, non-communicable diseases and injuries and violence.[18]

---

[9] Rural Health Advocacy Project, Budget Expenditure Monitoring Forum, SECTION 27 and Africa Health Placements "Press Statement: Austerity Measures Imposed on Eastern Cape Department of Health a Disaster for Rural Healthcare Delivery" 1 1 (2012) <http://www.rhap.org.za/wp-content/uploads/2012/05/Statement-about-EC-Budget-crisis_17-May-2012_RuDASA_-RHAP_-BEMF_SECTION27_AHP.pdf.> (accessed 22-05-2012).

[10] South African Human Rights Commission "Public Inquiry: Access to Health Care Services" (2007) 1 7 < http://www.info.gov.za/view/DownloadFileAction?id=99769> (accessed 13-01-2011).

[11] Department of Health "National Health Insurance in South Africa Policy Paper" (2011) 9 <http://www.info.gov.za/view/DownloadFileAction?id=148470> (accessed 11-08-2011).

[12] Department of Health "National Health Insurance" (2011) 9.

[13] South African Human Rights Commission "Public Inquiry" (2007) 13.

[14] R Amollo "The National Health Insurance Policy: What's in it for Women's Health?" (2012) 92 *Agenda* 111 112.

[15] Department of Health "National Health Insurance in South Africa Policy Paper" (2011) 12 para 37.

[16] South African Human Rights Commission "Public Inquiry" (2007) 4.

[17] South African Human Rights Commission "Public Inquiry" (2007) 6.

[18] Coovadia et al (2009) *The Lancet* 817. This culture of violence has been attributed (in part) to centuries of oppression through colonialism and apartheid and the current levels of poverty and inequality in South Africa. See: M Chopra, E Daviaud, R Pattinson, S Fonn & J E Lawn "Saving the Lives of South Africa's Mothers, Babies, and Children: Can the Health System Deliver?" (2009) 374 *The Lancet* 835 835; M

Of particular relevance is the high level of interpersonal violence, such as rape and domestic violence which predominantly affects women.[19] Today, such violence is effectively a leading cause of death and reduction in quality of life.[20] Women are also bearing a disproportionate burden of preventable sickness and communicable diseases in South Africa.[21] This is illustrated in the gendered nature of the HIV/AIDS epidemic,[22] and the exponential increase in maternal mortality in South Africa.[23] Additional obstacles to quality health care services include inadequate access to certain social determinants of health, such as clean water, sanitation and affordable and safe transport.[24] The burden of care that women predominantly experience[25] is further compounded by inadequate health care services, with women often compensating for such low quality health care services.[26] The challenges facing the public health care system therefore prevents the majority of South Africans from enjoying access to quality health care services. This reality is exacerbated for women by the gendered nature of poverty,[27] the HIV/AIDS epidemic and extreme levels of GBV, all of which prevents women from exercising their right to have access to health care services[28] on an equal basis.

Seedat, A Van Niekerk, R Jewkes, S Suffl & K Ratele "Health in South Africa Violence and Injuries in South Africa: Prioritising an Agenda for Prevention" (2009) 374 *The Lancet* 1011 1014.

[19] L Vetton "Man Shoots Wife: Intimate Femicide in Gauteng in South Africa" (1996) 6 Crime and Conflict 1-4 1 < http://www.csvr.org.za/wits/papers/papvet1.htm > (accessed 14-01-2011).

[20] Seedat et al (2009) *The Lancet* 1011.

[21] Department of Health "Annual Performance Plan" 2011 / 2012 – 2012 / 2013 <http://www.doh.gov.za/docs/stratdocs/2011/annual_plan11.pdf> (accessed 13-01-2012).

[22] S Chisala "Rape and HIV/AIDS: Who's Protecting Whom?" in L Artz & D Smythe (eds) *Should We Consent?: Rape Law Reform in South Africa* (2008) 52 55.

[23] According to Human Rights Watch maternal mortality has more than quadrupled within South Africa from 150 deaths per 100,000 live births in 1998 to 650 deaths per 100,000 in 2007. See: Human Rights Watch "Maternal Mortality in South Africa and Eastern Cape" in *Stop Making Excuses: Accountability for Maternal Health Care in South Africa* (2011) 1 19 <http://www.hrw.org/node/100757> (accessed 14-07-2011).

[24] E Paulus & A Simpson "Will Health Reform Proposals Realise the Right to Health of Women and Girl Children in Particular? A Reflection" (2011) 12 *ESR Review* 9 10.

[25] B Clark & B Goldblatt "Gender and Family Law" in E Bonthuys & C Albertyn (eds) *Gender, Law and Justice* (2007) 195 201-202.

[26] J Kehler "Women and Poverty: The South African Experience" (2001) 3 *Journal of International Women's Studies* 1 6 where she states that :

> "Women carry the brunt of the burden of finding alternatives for lack of service provision or when services are inaccessible due to costs."

[27] D Budlender "Women and Poverty" (2005) 64 *Agenda* 30 35; See also: J Dugard & N Mohlakoana "More Work for Women: A Rights -Based Analysis of Women's Access to Basic Services in South Africa" (2009) 25 *SAJHR* 546 546.

[28] Section 27(1) (a) of the Constitution.

3 3 Legislation and policy aimed at transforming the health care system

3 3 1 Introduction

In light of these substantial challenges, the democratic government has taken numerous legislative and policy steps since 1994 in an attempt to transform the South African health care system. There have however, been several setbacks along the way, such as the "AIDS denialism" of the Mbeki government and the initial limited provision of certain life-saving drugs, such as nevirapine.[29]

While the judicial interpretation of rights is an integral aspect of providing content to constitutional rights, the legislature and the executive also have an important role to play in translating these constitutional rights into individual entitlements. In particular, the legislature and the executive have a duty to provide the structures and resources necessary for people to exercise these rights. They are also specifically mandated to do so.[30] For example, section 7(1) of the Constitution mandates that the State must "respect, protect, promote and fulfil" the rights in the Bill of Rights. Section 9 of the Constitution states that in order to promote the achievement of equality, legislative and other measures may be taken. Section 27(1) (a) of the Constitution also states that everyone has the right to have access to health care services, including reproductive health care. Section 27(2) of the Constitution goes on to state that the right must be progressively realised through reasonable legislative and other measures, subject to available resources. The fact that the legislature is subject to resource and time constraints and may sometimes be influenced by powerful interest groups[31] further justifies the need to examine current government legislation and policy to determine its responsiveness to vulnerable groups.

In 1997, the ANC government introduced the White Paper for the Transformation of the South African Health Care System.[32] This document sought to ensure a paradigm

[29] C Kapp "New Hope for Health in South Africa" (2008) 372 *The Lancet* 1207 1207.
[30] Pieterse (2010) *Law, Democracy & Development* 2.
[31] S Liebenberg *Socio-Economic Rights Adjudication under a Transformative Constitution* (2010) 23 34.
[32] Department of Health "White Paper for the Transformation of the Health System in South Africa" 1997 <http://www.info.gov.za/whitepapers/1997/health.htm> (accessed 12-03-2012).

shift towards primary health care and a district health care system. The government has also taken certain legislative steps that have resulted in admirable change. These include the Pharmacy Amendment Act 88 of 1997 and the Medicines and Related Substances Control Amendment Act 90 of 1997. These two Acts are aimed at improving financial and administrative accountability within the public health care system, especially in relation to the pricing of medication and pharmaceuticals. The Medical Schemes Act 131 of 1998 has also attempted to make medical insurance more equitable. The Medical Schemes Act prohibits the registration of a medical aid scheme if it discriminates on the basis of race, gender, marital status, ethnic or social origin, sexual orientation, pregnancy, disability and 'state of health'.[33] The Medical Schemes Act goes on to establish the Council of Medical Schemes to ensure greater accountability. However, some of the most important developments for the public health care system have included the National Health Act 61 of 2003, and the Policy Paper on National Health Insurance.

3 3 2 The National Health Act 61 of 2003

The National Health Act (hereafter "NHA") 61 of 2003 was introduced to give effect to the White Paper for the transformation of the South African health care system.[34] Chapter 1, section 2(a), states that the purpose of the NHA is to create unified services while protecting and promoting the rights of vulnerable groups, such as women and children (section 2(c) (iv)).

Section 3(1) (d) states that the Minister of Health must ensure the provision of such essential health services, which must include primary health care services, to the population of the Republic. Section 3 (1) (e) also states that the Minister must equitably prioritise the health services that the State can provide. The Act echoes section 27(2) though, in that such health care services are limited by "available resources."

Section 4(3) (a) provides for free health care services for pregnant and lactating women and children below the age of six years, who are not members or beneficiaries of

[33] Section 24(2)(e) of the Medical Schemes Act 131 of 1998.
[34] Section 27 "The Statutory and Administrative Framework of the Public Health System" in *Health and Democracy* (2010) 94 100 <http://section27.org.za.dedi47.cpt1.host-h.net/2007/06/01/health-and-democracy/> (accessed 12-06-2012).

medical aid schemes. Section 4(3)(b) provides for free primary health care services for all persons, except members of medical aid schemes and persons receiving compensation for compensable occupational diseases. Free termination of pregnancy services are also mandated for women, subject to the Choice on Termination of Pregnancy Act 92 of 1996. Despite the articulation and recognition of such needs, research conducted by the South African Human Rights Commission in 2007 indicated that there was a severe disconnection between these provisions and their effective implementation. Thus, for example, only half of those who qualified for free health care services received an exemption from fees.[35]

Chapter 2 of the NHA provides for the rights and duties of users and providers of health care services. Giving content to section 27(3) of the Constitution, section 5 of the NHA specifically states that a health care provider may not refuse a person access to emergency medical health care. The NHA defines a "health care provider" as: "a person providing health services in terms of any law". This broad definition of health care provider illustrates that this obligation rests on both public and private health care providers.[36] However, the lack of a definition of "emergency medical treatment" in the NHA, or existing regulations is problematic and prevents certainty as to the precise obligations of health care providers.[37] While "health services" are defined in section 1 of the NHA,[38] the preamble of the NHA merely refers to emergency medical treatment as contemplated in section 27(3) of the Constitution.

While draft regulations which contained a definition of 'emergency medical treatment' were published in the Western Cape in 1999, Marius Pieterse points out that these regulations were never proclaimed[39] and that no further regulations that contain a definition of 'emergency medical treatment' have been released. The legislative and policy translation of section 27(3) has therefore been fragmented, appearing in separate

[35] South African Human Rights Commission "Public Inquiry" (2007) 41.
[36] Pieterse (2010) *Law, Democracy & Development* 13.
[37] D M Chirwa "'Non-state Actors' Responsibility for Socio-Economic Rights: The Nature of Their Obligations under the South African Constitution' (2002) 3 *ESR Review* 1 2.
[38] Section 1(g) states that "health services" means: (a) health care services, including reproductive health care and emergency medical treatment, contemplated in section 27 of the Constitution; (b) basic nutrition and basic health care services contemplated in section 28(l) (c) of the Constitution; (c) medical treatment contemplated in section 35(2)(e) of the Constitution; and (d) municipal health services.
[39] Pieterse (2010) *Law, Democracy & Development* 13.

documents that apply in different contexts.[40] For example, regulations promulgated in terms of the Medical Schemes Act 131 of 1998 defined emergency medical treatment as:

> "The sudden and, at the time, unexpected onset of a health condition that requires immediate medical or surgical treatment, where failure to provide medical or surgical treatment would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's life in serious jeopardy."[41]

The Hospital Association of South Africa has also published a draft code of ethics for private hospitals which defines "emergency medical treatment" as "treatment necessary to stabilise an emergency medical condition." [42] This vague definition and the fragmentation of provisions governing "emergency health care" makes legal certainty for patients, and for health care providers delivering emergency health care services, a challenge. In *Soobramoney v Minister of Health, KwaZulu-Natal*, [43] the Court's discussion on the right against refusal of emergency health care, further limited the application of section 27(3) to sudden and unforeseeable catastrophes.[44] While being logical in that limited resources necessitate a more limited construction of emergency medical care, this judgment has been criticised for curtailing the possible positive dimensions of this right.[45] Greater clarification on the meaning of 'emergency medical treatment', and the positive obligations on the State in this regard are therefore necessary.

Chapter 2 of the NHA does include provisions that have the potential to increase accountability within the public health care system. For example, the NHA regulates issues regarding consent and participation by the patient (section 7-8). Section 12

---

[40] Pieterse (2010) *Law, Democracy & Development* 14.
[41] "Regulations in terms of the Medical Schemes Act 131 of 1998" GN R 1262 in *GG* 20556 of 1999-10-20.
[42] Hospital Association of South Africa "Private Hospital Review 2008: Examination of Factors Impacting on Private Hospitals" (2008) 1 67 <http://www.hasa.co.za/media/uploads/documents/file/2011-08-04/HASA_HTG_Final_Report_-_January_2008.pdf> (accessed 12-05-2012).
[43] 1998 1 SA 765 (CC), 1997 12 BCLR 1696 (CC).
[44] *Soobramoney v Minister of Health, KwaZulu-Natal* 1998 1 SA 765 (CC); 1997 12 BCLR 1696 (CC) para 20.
[45] Liebenberg *Socio-Economic Rights* 138.

mandates the dissemination of certain vital information and section 18 allows for a publicised complaints system.

Chapter 3 focuses on the functions of the National Department of Health, while chapter 4 focuses on provincial health services. Chapter 5 provides for the duties and functions of the district health care system, as envisioned by the White Paper for the transformation of the South African health care system. Some of the more controversial provisions within the NHA are contained in chapter 6, which provides for the establishment of new health care facilities. Section 36 provides that a person may not establish a health establishment without a certificate of need. Section 36(3)(b) goes on to mandate that when issuing a certificate of need, the Director General must 'take into account' the need to promote an equitable distribution of health services and resources. Section 36(3)(b) also states that racial, gender, economic and geographic inequities need to be addressed when making this decision. This provision has the potential to assist in the necessary redistribution of quality health care establishments, and could therefore be used to promote equal access to health care services.[46]

The NHA seeks to regulate human resources development (chapter 7), which continues to be a problem in South Africa. The NHA also regulates the use of blood, blood products, tissue and gametes in humans (chapter 8) and national research and information on health (chapter 9). Chapter 10 regulates health officers and compliance procedures, while chapter 11 provides for the dissemination of regulations by the Minister of Health and chapter 12 contains general provisions.

In analysing the effective implementation of the NHA, certain problems are revealed. While the NHA recognises the health care needs of the vulnerable members of South Africa, these provisions appear to amount to little more than 'paper promises'.[47] For example a study conducted by Black Sash, an independent human rights NGO, revealed that special provisions are not made for vulnerable groups, such as pregnant women, the

[46] D Pearmain "Health Policy and Legislation in South Africa" (2007) 19 24 <http://www.hst.org.za/uploads/files/chap2_07.pdf> (accessed 12-02-2012).

[47] S Liebenberg "Giving Effect to Human Rights - The Role of the State" in *Human Development and Human Rights: South African Country Study. Human Development Report for the United Nations Development Programme* (2000) 16 16. Where she states that:

> "Without effective policies and laws to implement the human rights commitments in the Constitution and international instruments, these rights will amount to little more than paper promises."

elderly and children.[48] These groups are often required to stand for long periods of time due to extensive waiting periods. The NGO also reported an incident where a pregnant woman was turned away from a clinic three times due to the health care providers giving her the incorrect information.[49] The study by Human Rights Watch on maternal mortality further highlighted that women in labour are often turned away from hospitals, while being subjected to verbal and physical abuse.[50]

Women who are receiving treatment to prevent mother to child transmission of HIV/AIDS also experience discrimination. For example, certain hospitals provide HIV-positive pregnant women with green cards. These measures publicise the HIV/AIDS status of these women and often results in further discrimination from health care workers.[51] The South African Human Rights Commission has further highlighted that:

> "Medical and health personnel often have a poor or discriminatory attitude towards vulnerable individuals or groups, which leads to poor access to health care for vulnerable people."[52]

Despite the NHA's provision for the promotion of a more equitable redistribution of health care establishments,[53] there are still an insufficient number of health care clinics in rural areas. This inequality has gendered and spatial implications, with a disproportionately negative impact on women and children.[54] This imbalance is further problematic as it undermines the right to equality and the transformative vision of the Constitution.[55] In order to provide substantive content to the constitutional right to equality,[56] and the right to have access to health care services, there is therefore a need

[48] Paulus & Simpson (2011) *ESR Review* 11.
[49] Paulus & Simpson (2011) *ESR Review* 11.
[50] Human Rights Watch "Maternal Mortality" in *Stop Making Excuses* (2011) 1 1.
[51] Paulus & Simpson (2011) *ESR Review* 11.
[52] South African Human Rights Commission "Public Inquiry" (2007) 8.
[53] Section 36 of the National Health Act 61 of 2003 (hereafter the "NHA").
[54] Paulus & Simpson (2011) *ESR Review* 11-12.
[55] For example, Catherine Albertyn and Beth Goldblatt describe the goal of substantive equality as: "Embracing the idea of redistribution of power and resources and the elimination of material disadvantage."
See: C Albertyn & B Goldblatt "Equality in the Final Constitution" Equality in S Woolman, T Roux & M Bishop (eds) *Constitutional Law of South Africa* 2 ed (Original Service June 2008) 35 -1 5.
[56] Section 9 of the Constitution.

for improved implementation of section 36 of the NHA. There is also a need for greater redistributive efforts within the South African health care system in general.[57]

In relation to the content of the NHA, there is no mention of rape, domestic violence or GBV anywhere in the Act. Given that GBV is a brutal form of discrimination that exacerbates systemic inequalities,[58] this gap undermines the objective of the NHA to promote the rights of women. [59] It further fails to recognise that abused women are amongst the most vulnerable members of our society.[60] In contrast, the primary focus of the NHA is on maternal health care services and on the termination of pregnancies. While these services are necessary and admirable, they are insufficiently responsive to the broader health care needs of women in South Africa. For example, the NHA also fails to acknowledge cervical and breast cancer, despite the fact that more women are dying from cervical cancer than maternal mortality.[61] The NHA's limited approach to women's health care further exacerbates traditional social attitudes that place more value on women's reproductive functions, than on their own autonomy and power.[62]

The health consequences of GBV are also particularly devastating in some cases and should, at the very least, play an increased role in broadening the scope of health care services that are offered to women. The increase in maternal deaths in the public health sector further reveals that even these existing rights are not being effectively implemented within a human rights framework.

Research has also indicated that pregnant women are particularly vulnerable to violence and that reproductive health care services are a viable intervention point when addressing GBV.[63] Despite this research, there is no mention of addressing violence

[57] D McIntyre & L Gilson "Putting Equity in Health back onto the Social Policy Agenda: Experience from South Africa" 54 *Social Science & Medicine* (2002) 1637 1645.
[58] *S v Baloyi* 2000 2 SA 425 (CC); 2000 1 SACR 81 (CC) Justice Sachs (as he then was) stated in paragraph 12:
"To the extent that it is systemic, pervasive and overwhelmingly gender-specific domestic violence both reflects and reinforces patriarchal domination, and does so in a particularly brutal form."
[59] Section 2(c)(iv) of the NHA.
[60] Preamble to the Domestic Violence Act 116 of 1998 (hereafter the "DVA").
[61] S Mthembu "Cervical Cancer and Women Living with HIV in South Africa: Failure of AIDS Treatment Policy or Gendered Exclusions in Health Care?" 92 *Agenda* 35 36.
[62] C Albertyn "Gendered Transformation in South African Jurisprudence: Poor Women and the Constitutional Court" (2011) 3 *Stell LR* 591 604.
[63] L Gerntholtz, A Meerkotter, T Meyer, J Molefe, N Nsibande & L Vetten Tshwaranang Legal Advocacy Centre "Abused Women's Rights to Access Health Care Services – A Submission to the South African

against pregnant women in the NHA. There is also no mention of addressing the underlying gendered power imbalances which shape GBV and the HIV/AIDS epidemic.[64] Therefore, while the NHA recognises the vulnerability of certain groups, such as women, it fails to include any concrete provisions aimed at ameliorating the vulnerability of abused women. National health priorities could therefore be broadened to reflect the reality of GBV, and the broader health care needs of women.

3 3 3 The Policy Paper on National Health Insurance

Despite the provision that 'everyone' is entitled to have access to health care services in section 27(1)(a) of the Constitution, access to quality health care services is often hindered by the extensive costs of health care services. The policy paper on National Health Insurance (hereafter "NHI"), which is to be funded through a combination of a compulsory taxing system and an insurance scheme, thus seeks to give increased effect to section 27 (1)(a) of the Constitution. The NHI system will facilitate such transformation by ensuring that all South Africans will have access to a defined comprehensive package of appropriate and quality health care services, regardless of their socio-economic status.[65] The NHI system thus seeks to prevent discrimination, while improving access to quality health care services. Part of this plan includes the provision of all registered South Africans with a National Health Insurance card that will ease access to health care establishments.[66] The policy paper goes on to address the public/private imbalance by ensuring that health care services will be provided by appropriately accredited public and private health care providers.[67] The focus will also be on prevention at the community level, which is in contrast to a curative-based approach to health.

Human Rights Commission Public Inquiry into the Right to have Access to Health care Services" (2007) 6 <http://www.tlac.org.za/wpcontent/uploads/2012/01/Submission-sa-human-rights-commission-abused-womens-right-to-access-health-care-services.pdf> (accessed 12-01-2012).

[64] L Vetten & K Bhana (Centre for the Study of Violence and Reconciliation) "Violence, Vengeance and Gender: A Preliminary Investigation into the Links between Violence against Women and HIV/AIDS in South Africa" (2001) 1 4 < http://www.csvr.org.za/wits/papers/paplvkb.pdf> (accessed 06-03-2012).

[65] Department of Health "National Health Insurance in South Africa Policy Paper" (2011) 16 para 51.

[66] Department of Health "National Health Insurance in South Africa Policy Paper" (2011) 43 para 141.

[67] Department of Health "National Health Insurance in South Africa Policy Paper" (2011) 16 para 51.

The underlying principles that are intended to govern the NHI system include free access to health care services, social solidarity, effectiveness, appropriateness, equity, affordability and efficiency.[68] It is important to note however, that the policy paper states that the NHI system will benefit South African citizens and legal residents only. Therefore, short-term residents and foreigners will not be covered by the NHI system. In relation to refugees and asylum seekers, the policy paper simply states that their needs will be addressed in terms of the Refugees Act of 1998 and international human rights instruments that have been ratified by the State. Thus not 'everyone' in South Africa will be covered by the NHI system, despite section 27 of the Constitution stating that 'everyone' has the right to have access to health care services.

The policy paper points out the extensive socio-economic benefits in relation to the NHI system. For example, reference is made to how a NHI system can serve as a safety net against poverty, in that exorbitant health care fees can often send families on the socio-economic brink into abject poverty. The NHI system could therefore assist in alleviating the burden of care that many women experience, in addition to the feminisation of poverty. In relation to the implementation of the NHI system, the policy paper states that it will be implemented over a period of 14 years. The paper goes on to recognise the need for radical change in relation to the general administration and management of the public health care system.[69]

A pivotal focus of the NHI system will be on raising the quality of health care services that are currently offered in the public health system. The policy paper therefore provides for the Office of Health Standards Compliance which will be established by an Act of Parliament.[70] This body will set norms and standards for health facilities and will inspect health care establishments in order to determine whether they are complying with these standards. The NHI system also seeks to ensure that more specialists will be available at the primary health care level. The NHI goes on to recognise the severe shortage of human resources within the public health sector. The paper thus states that nursing

[68] Department of Health "National Health Insurance in South Africa Policy Paper" (2011) 16 para 52.
[69] Department of Health "National Health Insurance in South Africa Policy Paper" (2011) 5 para 6.
[70] Department of Health "National Health Insurance in South Africa Policy Paper" (2011) 31 para 97.

colleges and health science faculties will be supported so as to increase their capacity to produce more health professionals.

The National Department of Health's Strategic Plan for 2010/11-2012/13 [71] complements the policy paper and aims to improve human resource development and management, while revitalising the current infrastructure. It also aims towards accelerated implementation of health care services for HIV/AIDS and sexually transmitted diseases. These plans are specifically related to the effective implementation of the NHI system.

While the policy paper on the NHI system contains detailed provisions on how to address the increase in maternal mortality in South Africa, there is insufficient focus on improving the quality of services for survivors of GBV (hereafter "SGBV"), with no mention of health care services targeting domestic violence or rape. This is in spite of the recognition in both the National Strategic Plan and the policy paper on the NHI system that violence forms part of the quadruple burden of disease currently ailing South Africa.[72] The NHI policy paper further fails to provide any gender-disaggregated data on the burden of disease, while failing to address the broader health care burdens that women are experiencing, such as cervical and breast cancer. This is problematic as cervical cancer has been linked to domestic violence[73] and is currently a leading cause of death for women in South Africa.[74] Therefore, while the NHI system does have the potential to improve equal access to health care services for women, the specific needs of women should be further integrated in to the NHI policy document.[75] The potential of the NHI system to specifically address women's health care needs is furthermore, dependent on the State's ability to address the human (and other) resource crises that are currently facing the public health care system.[76] Given the extreme levels of GBV, it

[71] Department of Health "Strategic Plan for 2010/11-2012/13" (2010) <http://www.doh.gov.za/docs/stratdocs/2010/part1.pdf> (accessed 12-05-2011).
[72] Department of Health "National Health Insurance in South Africa Policy Paper" (2011) 7 para 17.
[73] Research has indicated that violence against women increases the risk of cervical cancer. See: A Coker, C Hopenhayn, C DeSimone, H Bush & L Crofford "Violence against Women Raises Risk of Cervical Cancer" (2009) 18 *Journal of Women's Health* 1179 1179.
[74] S Bornman, D Budlender, L Vetten, C van der Westhuizen, J Watson & J Williams (Women's Legal Centre) "The State of the Nation, Government Priorities & Women in South Africa: Decent Work, Education, Crime, Health, Rural Development & Land Reform" (2012) 40.
[75] Amollo (2012) *Agenda* 121.
[76] Amollo (2012) *Agenda* 113.

is submitted that services for SGBV should specifically be prioritised within the NHI policy paper.

3 3 4 The Promotion of Equality and the Prevention of Unfair Discrimination Act 4 of 2000

The Promotion of Equality and the Prevention of Unfair Discrimination Act (hereafter "The Equality Act") prohibits discrimination against women on the basis of gender and specifically prohibits GBV as a form of discrimination.[77] In relation to equal access to health care, the Equality Act prohibits the limitation of women's access to social services or benefits such as health care services[78] (section 8(g)). The Equality Act also prohibits unfair practices in its schedule. For example, the Equality Act prohibits the denial or refusal of any person to access health care facilities. It also prohibits the failure to make health care facilities accessible to any person. The Equality Act further prohibits refusing to provide emergency medical treatment to persons of particular groups identified by one or more of the prohibited grounds. This broad provision arguably applies to both private and public health care service providers. It also provides additional support for holding government accountable in improving equal access to quality health care services for the majority of South Africans.

3 3 5 Conclusion

The provision that 'everyone' is entitled to have access to health care services in section 27(1)(a) of the Constitution contains an equality-threshold that forbids any discrimination in the provision of health care services.[79] Furthermore, section 9(2) of the Constitution provides that equality includes the full and equal enjoyment of all the constitutional rights. The legislative framework also provides for equal access to health

[77] Section 8(a) of the Promotion of Equality and Prevention of Unfair Discrimination Act 4 of 2000 (hereafter "The Equality Act").
[78] Section 8(g) of the Equality Act.
[79] M Pieterse *A Benefit-Focused Analysis of Constitutional Health Rights* DPhil dissertation University of Witwatersrand (2005) 68.

care services, with the NHA stating that no one may be refused emergency health care (section 5) and that the Minister of Health must equitably prioritise the services that the State can provide (section 3(1)(e)). The Equality Act also prohibits the limitation of women's access to health care services (section 8).

Despite this progressive constitutional and legislative framework prohibiting discrimination, Rebecca Amollo points out that the current approach to medical aid schemes effectively commercialises health care in South Africa.[80] Those who cannot afford medical aid face the anxiety of being unable to deal with future health crises, given the low quality of health care services that are provided by the public health care system. This is particularly relevant when specialist care is needed. This was raised in the case of *Law Society of South Africa and Others v Minister for Transport and Another*,[81] where the Court held that forcing quadriplegics or paraplegics to rely on public health care services would lead to their inevitable demise.[82] The lack of quality health care services in the public health sector is further illustrated in the exponential increase in maternal mortality.[83] Low quality health care services also have a particularly detrimental impact upon vulnerable groups, such as women and children.[84]

The need to improve the health care system has subsequently led to wide support for the proposed tax-funded NHI system.[85] Pursuing the NHI system is also one strategy to effectively de-commercialise health care in South Africa.[86] Even though the policy paper has great potential to further transform the South African health care system, the paper itself highlights the problem of maladministration in the public health care system and the need to address it.[87] Both the NHA and the NHI lack any health care interventions for SGBV, representing a significant exclusion of abused women from health care legislation and policy. The lack of provisions addressing cervical and breast cancer also reveals a failure to address the broader health care needs of women, in general. This exclusion

[80] Amollo (2009) *ESR Review* 14.
[81] 2011 1 SA 400 (CC).
[82] *Law Society of South Africa and Others v Minister for Transport and Another,* 2011 1 SA 400 (CC) para 96.
[83] Human Rights Watch "Maternal Mortality in South Africa" in *Stop Making Excuses* (2011) 19.
[84] Paulus & Simpson (2011) *ESR Review* 11-12.
[85] Paulus & Simpson (2011) *ESR Review* 11-12
[86] Amollo (2009) *ESR Review* 16.
[87] Department of Health "National Health Insurance in South Africa Policy Paper" (2011) 5 para 6.

thus undermines the constitutional commitment to a society based on non-sexism[88] and needs to be addressed by the government.

3 4 Legislation and policy addressing domestic violence

3 4 1 Introduction

One in four women in South Africa experience domestic violence in their lifetime.[89] Such violence has numerous fatal and non-fatal health consequences[90] that need to be addressed by the State. One of the first pieces of legislation aimed at curbing domestic violence was the Prevention of Family Violence Act 133 of 1993, which effectively outlawed marital rape. While the Act brought about important change, it suffered from a lack of a definition of family violence and failed to recognise the various forms of South African intimate relationships. After the democratic elections of 1994 attempts were made to address these shortcomings. These efforts, which took place over a period of two years, eventually culminated in the progressive and ambitious provisions of the Domestic Violence Act 116 of 1998.[91]

3 4 2 Domestic Violence Act 116 of 1998

The Domestic Violence Act 116 of 1998 (hereafter “DVA”) recognises in its preamble that domestic violence is a serious social evil, and that the victims of domestic violence are among the most vulnerable members of our society. While the DVA places specific responsibilities on police personnel to assist complainants of domestic violence, the DVA is notably silent as to the role of the Department of Health, in addition to the Department of Social Development. The Act is progressive however, in that it contains a wide recognition of domestic relationships, in addition to a broad description of domestic

[88] Section 1(b) of the Constitution.
[89] Seedat et al (2009) *The Lancet* 1015.
[90] These health consequences are discussed in detail in chapter 1, pages 2-3.
[91] L Vetten "Show Me the Money": A Review of Budgets Allocated Towards the Implementation of the Domestic Violence Act (no. 116 of 1998)” (2005) 32 *Politikon* 277 281.

violence.[92] For example, the Act provides protection for same-sex partnerships, people who were or are engaged, people in a dating or customary relationship and people who are living together or separately. The Act therefore provides protection to anyone in a domestic relationship, and effectively responds to the reality of South African society.

The definition of 'domestic violence' is also broad in that it includes physical abuse, sexual abuse, emotional, psychological and verbal abuse, economic abuse, intimidation, harassment, stalking, damage to property and entry into a complainant's residence without permission, where the parties do not share a residence. The DVA also incorporates in the definition of domestic violence:

> "Any other controlling or abusive behaviour towards a complainant, where such conduct harms, or may cause imminent harm to, the safety, health or wellbeing of the complainant."[93]

This effectively provides recognition of the many manifestations of nuances of abuse that can occur within private relationships. The DVA goes on to place specific obligations on the Police Services, stating that the police must assist complainants in obtaining medical treatment, accessing shelter and in retrieving goods from the shared property.[94] The DVA further allows a complainant to apply to a court for a protection order, including an interim order before a final order is granted.[95] In this regard the Act provides a court with broad powers to tailor the terms of a protection order to the specific needs of an applicant. A protection order may therefore prohibit a respondent from committing any act of domestic violence or from entering a specified place.[96] Respondents can also be instructed to pay rent or mortgage as well as to provide money for food and other necessary household expenses. In some circumstances, respondents may also be prevented from having contact with a child or children from the relationship. In addition,

[92] Section 1 of the DVA.
[93] Section 1(viii) (j) of the DVA .
[94] Section 2(a) of the DVA.
[95] Section 4 of the DVA.
[96] In *Omar v Government of the Republic of South Africa and* Others (Commission for Gender Equality, Amicus Curiae) 2006 2 SA 289 (CC); 2006 2 BCLR 253 (CC) the Constitutional Court dealt with the constitutionality of section 8(1) of the Domestic Violence Act 116 of 1998 which allows a court to issue a suspended warrant of arrest, when issuing a protection order. The Court held that that the DVA was constitutional, in light of the high levels of domestic violence in South Africa.

courts may order the police to remove the respondent's guns or other dangerous weapons, as well as provide a protective escort to the applicant while she fetches clothing or other personal items from the home. The DVA also mandates that a court must, as soon as is reasonably possible, hear an application for a protection order in terms of section 4,[97] and may hear such evidence as it deems necessary. These provisions aim to facilitate access to the criminal justice system. While laudable, these provisions would have been better supported by the inclusion of positive duties on the Department of Health. The failure to include such positive duties thus undermines the effectiveness of the DVA and is discussed in more detail below.

3 4 3 Challenges facing the Domestic Violence Act

Despite the progressive provisions within the DVA, there is a severe disconnection between these impressive rights and everyday practice in South Africa. With regards to the content of the DVA, the definition of domestic violence in section 1 has been criticised for not effectively recognising the continuing nature of such violence.[98] For example, Dr Bonita Meyersfeld has pointed out that the description of any controlling or abusive behaviour that "harms, or may cause imminent harm to the complainant" is inadequate. She points out that an individual act of domestic violence that may appear trivial, and which may not cause 'imminent harm', may effectively contribute to long-term harm.[99] This appears particularly relevant in relation to the psychological harm that is often caused by domestic violence, such as depression, post-traumatic stress disorder and even suicide.

The greatest area of criticism, however, has been the gap left in the DVA by the exclusion of specific duties on the Department of Health and the Department of Social Development.[100] Of particular concern is that while the DVA places legal duties on law enforcement personnel, it does not place parallel responsibilities on health care workers,

[97] Section 5 of the DVA.
[98] B Meyersfeld *Domestic Violence and International Law* (2010) 151 159.
[99] Meyersfeld *Domestic Violence* 159.
[100] C Doolan "Missing Piece in the Puzzle: The Health Sector's Role in Implementing the Domestic Violence Act" (2005) 12 *SA Crime Quarterly* 9 9.

despite the fact that health care workers are often ideally situated to identify GBV. For example, research has indicated that in South Africa, the health sector is the first and most frequently utilised sector by abused women.[101] Research has also illustrated that health programmes that address GBV may prevent the escalation of abuse.[102] Given the high level of intimate femicide in South Africa,[103] placing duties on the Department of Health thus appears to be a legitimate intervention point.

The lack of duties on health care workers to address domestic violence further illustrates a failure by the State to recognise domestic violence as a public health crisis and a human rights priority. Therefore, the DVA in its current form is insufficiently responsive to the needs of abused women and does not give effect to the broader constitutional rights of such women.[104]

The neglect of specific duties on the Department of Health has further implications in relation to the quality of health care services offered. With the Department of Health having no responsibilities to address domestic violence, there is a lack of adequate training of health care providers and a lack of quality control. Health care providers who are inadequately trained are often unable to confidentially inquire about, and document, domestic violence in a manner that protects an abused woman's rights to dignity and privacy.[105] Untrained health care workers are also often unprepared to testify in court.[106] The lack of a sensitised multi-sectoral response thus often exposes women to secondary victimisation.

The attitudes and inadequate training of police officials is an additional challenge to the effective implementation of the DVA. Despite the fact that the DVA specifically mandates that the Police Services must assist complainants in obtaining medical

---

[101] P Parenzee, L Artz & K Moult "Monitoring the Implementation of the Domestic Violence Act: First Research Report 2000-2001" (2001) 1 91 <http://www.ghjru.uct.ac.za/osf-reports/dva-report.pdf.> (accessed 05-09-2011).

[102] United States Agency for International Development "Addressing Gender-based Violence through USAID'S Health Program: A Guide for Health Sector Programme Officers" (2006) 1 9 < http://www.prb.org/pdf05/gbvreportfinal.pdf> (accessed 12-04-2012).

[103] Every six hours a woman is murdered by her intimate partner in South Africa, See: Vetton "Man Shoots Wife" (1996) 6.

[104] L J Martin & T Jacobs (Consortium on Violence against Women) "Screening for Domestic Violence: A Policy and Management Framework for the Health Sector" <http://www.ghjru.uct.ac.za/osf-reports/protocol.pdf> (accessed 12-04-2010).

[105] Doolan (2005) *Crime Quarterly* 9.

[106] Doolan (2005) *Crime Quarterly* 9.

treatment (section 2(a) of the DVA), the criminal case of *S v Engelbrecht* [107] revealed the practical challenges of implementing such measures. In *Engelbrecht*, evidence that was presented before the court revealed that when Mrs Engelbrecht had phoned the emergency services the police dispatchers had argued with her about why they were not going to assist her.[108] Furthermore, despite the detailed provisions of section 2(a) of the DVA, many police officials do not believe that it is their responsibility to escort complainants to health care facilities. This apathy further delays timely access to quality health care services for survivors of domestic violence.

Research has also revealed that there is a lack of knowledge regarding the procedural provisions of the DVA. For example, in a study conducted by Gender Links and the Medical Research Council, it was effectively revealed that only 9.8 % of the police stations in Gauteng actually complied with the DVA.[109]

The lack of accountability for police personnel who fail to adhere to their specific duties in terms of the DVA, in addition to negative perceptions around why women obtain protection orders, is also problematic. Lisa Vetten has stressed the need for adequate training, in addition to the need for a system of accountability. She has also asserted the need for a specific policing strategy that is tailored to the unique nature of domestic violence.[110] It is submitted that a unique strategy is also required in relation to the provision of health care services for abused women, as deeply entrenched patriarchal

---

[107] *S v Engelbrecht 2005* 2 SACR 41 (W). In this case Mrs Engelbrecht had murdered her husband after years of severe abuse which included :

> "Manhandling and beating, verbal insults and threats, sexual violation and ridicule, attempts to isolate her from others, electronic monitoring and physical surveillance, sleep deprivation, enforcement of trivial demands, economic restrictions, physical, psychological and emotional humiliation and degradation both publicly and privately, destruction of property in her present control and domination at his hands" para 361.

After enduring such horrific abuse and subsequently attempting on numerous occasions to apply for a protection order Mrs Engelbrecht finally handcuffed her sleeping husband to their bed and smothered him. Ultimately, the court found that the murder of her husband had been planned and pre-meditated and therefore outside of the bounds of private defence.

[108] L Vetton "Addressing Domestic Violence in South Africa: Reflections on Strategy and Practice" (2005) 1-12 10 < http://www.un.org/womenwatch/daw/egm/vaw-gp-2005/docs/experts/vetten.vaw.pdf > (accessed 12-04-2011).

[109] M Machisa, R Jewkes, C L Morna & K Rama "Response to Gender-based Violence" in *The War at Home* (2011) <http://www.genderlinks.org.za/article/the-war-at-home---gbv-indicators-project-2011-08-16> (04-05-2012) 89 96.

[110] L Vetten, T Le, A Leisegang & S Haken "*The Right and The Real: A Shadow Report Analysing Selected Government Departments' Implementation of the 1998 Domestic Violence Act and 2007 Sexual Offences Act*" (2010) 28.

views play a role in preventing women from accessing health care services. For example, in a research study undertaken by Rachel Jewkes, it was revealed that certain health care providers have deeply entrenched beliefs regarding GBV. Even after receiving training, the research revealed that although there were some improvements, in certain cases, negative perceptions were further entrenched. [111]

There are also intersecting factors that further limit access to health care services for abused women.[112] For example, discrimination on the grounds of poverty, disability, citizenship, sexual orientation and geography often compounds ineffective access to appropriate health care services. This is illustrated by women who live on farms, or in rural areas. Not only are these women particularly vulnerable to domestic violence, but they are also disproportionately affected by the lack of health care establishments in rural areas. This was highlighted by Lillian Artz and Dee Smythe with the statement that:

> "Our research on farms in the Western Cape has shown that in a context of deeply entrenched structural dependency, with very few exit opportunities available to women, the Act is largely ineffective."[113]

The DVA can also only be enforced in Magistrates' Courts or Family Courts, which only function in urban areas. [114] The failure to enable traditional courts to issue protection orders combined with social, cultural, linguistic and economic reasons may thus compound the limited ability of many rural women to utilise the DVA.[115] Research has confirmed this imbalance, in that women who apply for a protection order are far more likely to be employed, and therefore less likely to be economically vulnerable. [116]

---

[111] N Cristofides & R Jewkes "Acceptability of Universal Screening for Intimate Partner Violence in Voluntary HIV Testing and Counseling Services in South Africa and Service Implications" (2010) 22 *Aids Care* 279 283.
[112] M Pieterse "The Interdependence of Rights to Health and Autonomy in South Africa" (2008) 125 *SALJ* 553 555.
[113] L Artz & D Smythe "Bridges and Barriers: A Five Year Retrospective on the Domestic Violence Act" (2005) *Acta Juridica* 200 205.
[114] E Currin & E Bonthuys "Customary Law and Domestic Violence in Rural South African Communities" (2005) 21 *SAJHR* 607 608.
[115] Currin & Bonthuys (2005) *SAJHR* 608.
[116] S Mathews & N Abrahams "Combining Stories and Numbers: An Analysis of the Impact of the Domestic Violence Act (No.116 of 1998) on Women" Medical Research Council Policy Briefs & Research Reports (2001) 1 2 <http://www.mrc.ac.za/gender/domesticviolence.pdf> (accessed 14-02-2011).

Therefore, in order to be effective, interventions addressing domestic violence need to address the health care needs of such women, while being sensitive to the socio-economic circumstances of these women.

This reveals that the development of an appropriate health care response to domestic violence will necessarily have resource implications. In this regard, the lack of implementation of the DVA has been linked to the lack of political support for domestic violence. For example, the budget votes for the Department of Justice and Constitutional Development, the South African Police Services and the Independent Complaints Directorate have been criticised for failing to determine the costs for the implementation of the DVA.[117] Therefore, as Lisa Vetten points out, the absence of a costing framework has resulted in "severely impeded" service delivery and "poor implementation" of the DVA.[118] This reveals how domestic violence has been neglected as both a political and a public health priority.

3 4 4 Relevant health policy addressing domestic violence

Given the severe health consequences of domestic violence,[119] there is a need for quality and holistic health care services for abused women. For example, while physical violence may be the easiest form of domestic violence to identify, intimidation, psychological abuse and sexual abuse also carry severe health consequences that need to be effectively addressed.

Currently, the Department of Health's policy response to domestic violence is somewhat fragmented and includes: The Primary Health Care Package for South Africa – A Set of Norms and Standards (hereafter the "primary health package"),[120] The National Guidelines on Prevention, Early Detection/Identification and Intervention of

[117] Vetten et al "*The Right and the Real*" (2010) 48-49.
[118] Vetten et al "*The Right and the Real*" (2010) 2.
[119] Seedat et al (2009) *The Lancet* 1011.
[120] Department of Health "The Primary Health Care Package for South Africa – A Set of Norms and Standards" in Department of Health Policy Documents (2000) 1 57 <http://www.doh.gov.za/docs/index.html> (accessed 01-03-2011).

Physical Abuse of Older Persons at Primary Level;[121] The National Implementation Plan for the Service Charter for Victims of Crime 2007-2011;[122] and The National Strategic Plan for HIV and AIDS, STIs and TB, 2012-2016.[123]

The primary health package for South Africa includes reproductive health care for women, mental health services and services for survivors of sexual abuse, domestic violence and gender violence.[124] It also includes counselling and referral of victims, STI prophylaxis and HIV testing, emergency contraception, care of injuries, medico-legal advice and documentation of evidence. Despite the inclusion of mental health services, researchers have identified the inadequate resourcing and provision of such health care services in South Africa in general.[125] Poverty, the biomedical orientation of health care services[126] and desensitised and overworked health care workers provide additional obstacles to effective access to quality mental health care services.[127] In addition, even where such services are technically available, many abused women are not enjoying access to such services due to operational or institutional barriers. For example, a research study presented by the Medical Research Council on the effective implementation of the DVA stated that a significant number of abused women suffered from severe depression without their condition being diagnosed or adequately managed.[128]

In relation to the nature of services provided, despite the inclusion of STI prophylaxis, survivors of domestic violence are seldom screened to determine whether they require

[121] Department of Health "The National Guidelines on Prevention, Early Detection/Identification and Intervention of Physical Abuse of Older Persons at Primary Level" (2000) <http://webapps01.un.org/vawdatabase/uploads/National%20guideline%20on%20prevention%20of%20physical%20abuse%20of%20elderly%20persons.pdf> (accessed 12-11-2011).
[122] Department of Justice and Constitutional Development "National Implementation Plan Service Charter for Victims of Crime" (2007) <http://www.info.gov.za/view/DownloadFileAction?id=123931> (accessed 12-10-2011).
[123] National Department of Health of South Africa "The National Strategic Plan for HIV and AIDS, Sexually Transmitted Infections and Tubercolosis, 2012 - 2016" (2011) <http://www.sanac.org.za/files/uploaded/519_NSP%20Draft%20Zero%20110808%20pdf%20%20final.pdf> (accessed 12-05-2011).
[124] Department of Health "The Primary Health Care Package for South Africa" (2000) 57.
[125] I Petersen "Comprehensive Integrated Primary Mental Health Care for South Africa: Pipedream or Possibility?" (2000) 51 *Social Science & Medicine* 321 330.
[126] Health care services have been primarily shaped by the biological aspects of medicine, often ignoring the mental or the emotional forms of distress that can negatively affect the body.
[127] Peterson (2000) *Social Science & Medicine* 325.
[128] Mathews & Abrahams (2001) Medical Research Council Policy Briefs & Research Reports 1 2.

post-exposure prophylaxis (hereafter "PEP").[129] This is in spite of the extensive levels of violent sexual abuse that occurs in abusive partnerships.[130] This reveals that the holistic health care needs of women subjected to domestic violence are still being neglected.

The Primary Health Care Package of South Africa also seeks to develop a response to GBV that is more multi-sectoral by providing that:

> "Every clinic has established working relationships with the nearest police officer and social welfare officer by having visits from them at least twice a year."

This provision is however insufficient, given the high levels of rape and domestic violence that occur within South Africa. The National Implementation Plan for the Service Charter for Victims of Crime 2007-2011, effectively elaborates on the Department of Health's duties towards victims of violence. The Implementation Plan requires that health care providers record physical injuries from abuse, open files for patients who have experienced violence and inform such patients of their rights to pursue prosecution against their perpetrator. The Implementation Plan has unfortunately suffered from severe implementation problems. For example, research has revealed that health care providers often fail to recognise GBV, let alone document injuries from such violence.[131] In addition, in a study conducted by the Commission for Gender Equality, it was pointed out that there is a lack of materials on the Victims' Charter at certain police stations, while many police stations lack an anti-rape strategy, leading to a lack of coordination between

---

[129] According to the World Health Organisation Post Exposure Prophylaxis refers to:
"The set of services that are provided to manage the specific aspects of exposure to HIV and to help prevent HIV infection in a person exposed to the risk of getting infected by HIV. These services might comprise first aid, counselling including the assessment of risk of exposure to the infection, HIV testing, and depending on the outcome of the exposure assessment, the prescription of a 28-day course of antiretroviral drugs, with appropriate support and follow-up."
See: World Health Organisation &International Labour Organisation "Post-exposure Prophylaxis to Prevent HIV Infection: The Joint World Health Organisation and International Labour Organisation Guidelines on Post-exposure Prophylaxis (PEP) to Prevent HIV Infection" (2007) 1- 104 9 <http://whqlibdoc.who.int/publications/2007/9789241596374_eng.pdf> (accessed 14-03-2011).

[130] Tshwaranang Legal Advocacy Centre "Abused Women's Rights to Access Health Care Services (2012) 7.

[131] K Joyner *Health Care for Intimate Partner Violence: Current Standards of Care and Development of Protocol Management* DPhil thesis Stellenbosch University (2009) 1 103.

the criminal justice system and the health care system.[132] The Implementation Plan has also been criticised for its prioritisation of the criminal justice system, and its lack of prioritisation for the needs of women.

One of the objectives of the National Strategic Plan for HIV and AIDS, STIs and TB, 2012-2016 is to reduce vulnerability to GBV by scaling up prevention interventions and comprehensive services for survivors of sexual assault. It also focuses on increased communication and advocacy measures to reduce such violence. While this policy document is important for its effective recognition of the important link between the spread of HIV/AIDS and GBV, it primarily focuses on services for survivors of rape, neglecting the health care needs of survivors of other forms of violence, such as human trafficking and domestic violence. Furthermore, despite the reference to the need to scale up prevention interventions, there are very few interventions that actually address GBV in South Africa.[133]

3 4 5 Conclusion

The DVA needs to be praised for its many progressive provisions, which have brought about positive shifts in government policies addressing domestic violence.[134] However, these innovative provisions will remain ineffective without an enabling environment to facilitate implementation. In this regard, the attitudes and perceptions of police personnel and health care workers effectively serve as obstacles to women obtaining full and equal access to health care services.[135] As pointed out by Bonita Meyersfeld, the apathy of certain state officials further exacerbates the normalisation of GBV,[136] while infringing upon the dignity of abused women. Adequate training and sensitisation of health care

[132] South African Commission for Gender Equality "Research Report on the Victims' Charter" (2009) 1 23 <http://www.cge.org.za/index.php?option=com_docman&task=cat_view&gid=43&limitstart=5.> (accessed 10-05-2012). See also: A Meerkotter, Tshwaranang Legal Advocacy Centre "Domestic Violence, Health and HIV: A Review on the Progress Made in Addressing Domestic Violence Through the *HIV & AIDS and STI National Strategic Plan 2007-2011"* (2009) 3 *Policy Brief* 1 4.
[133] R Jewkes "Vezimfilho: A Model for Health Sector Response to Gender Violence in South Africa" (2002) 78 *International Journal of Gynecology and Obstetrics* 51 52.
[134] Artz & Smythe (2005) *Acta Juridica* 200.
[135] Jewkes (2002) *International Journal of Gyneceology and Obstetrics* 52.
[136] Meyersfeld *Domestic Violence191*.

workers is therefore required, in addition to improved accountability. The training of health care workers will also need to be accompanied by a multi-sectoral approach.[137]

In *Government of the Republic of South Africa and Others v Grootboom and Others*,[138] (hereafter "*Grootboom")* which was discussed in detail in chapter two,[139] the Constitutional Court considered the constitutionality of the nationwide housing programme. The Court held that a government programme needs to be flexible, comprehensive, coherent and capable of facilitating the realisation of the relevant right. The Court went on to emphasise that:

> "To be reasonable, measures cannot leave out of account the degree and extent of the denial of the right they endeavour to realise. Those, whose needs are the most urgent and whose ability to enjoy all rights therefore is most in peril, must not be ignored by the measures aimed at achieving realisation of the right…Furthermore, the Constitution requires that everyone must be treated with care and concern. If the measures, though statistically successful, fail to respond to the needs of those most desperate, they may not pass the test." [140]

This reveals that policy provisions on health care services for survivors of domestic violence, which are currently scattered throughout different documents, need to be consolidated. [141] Even when viewed collectively these documents fail to provide sufficiently coherent guidelines for health care providers on how to address and respond to suspected domestic violence. Given the high levels of domestic violence, in addition to the high levels of intimate femicide, women who experience domestic violence have particularly urgent needs that require sufficient care and concern. The lack of national guidelines on health care interventions for domestic violence therefore neglects the health care needs of a particularly vulnerable group within South Africa.

The neglect of emotional and psychological health care needs further compounds the vulnerability of abused women. For example, the South African Stress and Health study

---

[137] Jewkes (2002) *International Journal of Gynaecology and Obstetrics* 55.
[138] 2001 1 SA 46 (CC); 2000 11 BCLR 1169 (CC).
[139] Chapter two, pages 32-35.
[140] *Government of the Republic of South Africa and Others v Grootboom and Others* 2001 1 SA 46 (CC); 2000 11 BCLR 1169 (CC) para 44.
[141] Domestic violence is mentioned in the Primary Health Care Package, the National Implementation Plan and the National Strategic Plan.

has publicised that domestic violence is associated with the greatest number of lifetime post-traumatic stress disorder cases amongst women.[142]

There is therefore, clearly a need for an improved health care response to domestic violence. This could include the provision of consolidated national guidelines that provide for access to holistic health care services for women who have been subjected to domestic violence. The specific services that should be provided to survivors of domestic violence are discussed in detail in chapter five.[143] From the above consideration of *Grootboom* however, it is clear that such services need to be consolidated, while comprehensively facilitating the realisation of the right to have access to health care services, including reproductive health care, for abused women in South Africa.

3 5 Legislation and policy addressing sexual violence

3 5 1 Introduction

In 2010 Human Rights Watch stated that South Africa has the highest rates of rape in the world.[144] The health consequences of rape include both physical and psychological consequences that need to be managed appropriately.[145] In relation to the emotional and psychological consequences of rape, Jennifer Nedelsky refers to the "shattering consequences"[146] of such violence and highlights the "fear of rape that pervades and controls the lives of women."[147] Intersecting this fear is the uncertainty and anxiety of having to access public health care services if one cannot afford private health care. The stigma attached to rape and the inadequate social support that often accompanies it,

[142] D Kaminer, A Grimsrud, L Myer, DJ Stein & DR Williams "Risk for Post-traumatic Stress Disorder Associated with Different Forms of Interpersonal Violence in South Africa" (2008) 67 *Social Science & Medicine* 1589 1589.
[143] See chapter 5, pages 149-158.
[144] Human Rights Watch "South Africa" in *Human Rights Watch World Report* (2010) 164 166.
[145] Such needs include the prevention of pregnancy, the prevention of the spread of HIV/AIDS and sexually transmitted infections, the prevention of urinary tract infections and the provision of appropriate psychological support and counselling. See: J Christofides, D Muirhead, R K Jewkes, L Penn-Kekana, D N Conco "Women's Experiences of, and Preferences for, Services after Rape in South Africa: Interview Study" (2006) 332 *British Medical Journal* 209 209-210.
[146] J Nedelsky "Violence against Women" Challenges to the Liberal State and Feminism" in J Nedelsky *Law's Relations: A Relational Theory of Self, Autonomy, and Law* (2011) 200 209.
[147] Nedelsky "Violence against Women" in Nedelsky *Law's Relations* (2011) 209.

also have a debilitating impact upon the ability to access and adhere to necessary health care.[148] There are also broader social consequences resulting from the trauma of rape. Such consequences include dropping out of school, loss of function at work, difficulties in sexual expression and in some cases, the diminished capacity to perform everyday necessary functions.[149]

In light of the devastating health consequences of rape, the current treatment of rape survivors by police and health care workers in South Africa has been criticised as sub-standard.[150] The health consequences of rape therefore need to be recognised and addressed with sufficient resources and attention if we are to be seriously committed to the constitutional values of human dignity, equality and freedom.[151]

3 5 2 Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007

The aim of the Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007 (hereafter the "SOA"), is to afford complainants of sexual offences "the maximum and least traumatising protection that the law can provide".[152] In relation to the definition of rape, the SOA needs to be praised for its progressive development of the law, with rape now defined as both gender-neutral[153] and orifice-neutral.[154] While consent has remained an element of the crime of rape, it is now broadly defined, with consent

---

[148] N Abrahams & R Jewkes "Barriers to Post Exposure Prophylaxis (PEP) Completion after Rape: A South African Qualitative Study" (2010) 12 *Culture, Health & Sexuality* 471 471.

[149] Department of Health "National Sexual Assault Policy" (2005) 1, 5 <http://webapps01.un.org/vawdatabase/uploads/National%20Sexual%20Assault%20Policy%20-%202005.pdf> (accessed 15-04-2011).

[150] J Kim, L Mokwena, E Ntlemo, N Dwane, A Noholoza, T Abramsky, E Marinda, I Askew, J Chege, S Mullick, L Gerntholtz, L Vetten, & A Meerkotter "Developing an Integrated Model for Post-rape Care and HIV Post-exposure Prophylaxis in Rural South Africa" (2007) i 2 <http://pdf.usaid.gov/pdf_docs/PNADK615.pdf.> (accessed 12-06-2012).

[151] Section 1 of the Constitution.

[152] Section 2 of the SOA.

[153] In the Constitutional Court case of *Masiya v Director of Public Prosecutions Pretoria (The State) and Another* 2007 5 SA 30 (CC); 2007 8 BCLR 827, the Court extended the common law definition of rape to include the non-consensual sexual penetration of the male penis into the vagina or anus of another person.

[154] The definition of ''sexual penetration'' in section 1 of the SOA broadened the definition of rape even further and includes any act which causes penetration to any extent whatsoever by
(a) the genital organs of one person into or beyond the genital organs, anus, or mouth of another person;
(b) any other part of the body of one person or, any object, including any part of the body of an animal, into or beyond the genital organs or anus of another person; or
(c) the genital organs of an animal, into or beyond the mouth of another person.

explicitly excluded when obtained under threat of harm, where there has been an abuse of power or authority and where the victim has been misled in relation to the nature of the act or the identity of the person performing the sexual act. Consent is also excluded where the victim is asleep, unconscious, in an altered mental state, mentally disabled or below 12 years of age. [155]

Despite the innovative changes that have been introduced by the SOA, there has been some controversy over certain sections, in addition to severe implementation problems. For example, recently it was highlighted that the SOA failed to provide a penalty for the crime of sexual assault contained in section 5(1) of the SOA.[156] The legality principle in criminal law expressed in the maxim *nulla poena sine lege,* states that there can be no punishment without a law. In *Director of Public Prosecutions, Western Cape v Prins,*[157] the accused therefore alleged that the SOA failed to introduce a crime in this regard. On appeal, the Supreme Court of Appeal held that there can be no doubt that the SOA created criminal offences.[158] The court specifically referred to the objectives of the SOA, which includes combating sexual offences through criminalising all forms of sexual abuse or exploitation. The court also specifically pointed out that:

> "No judicial officer sitting in South Africa today is unaware of the extent of sexual violence in this country and the way in which it deprives so many women and children of their right to dignity and bodily integrity."[159]

Shortly after the High Court judgment was delivered, Parliament also met and passed an amending Bill,[160] which expressly provides that the powers of courts in regard to sentence for the offences in chapters 2, 3 and 4 of the SOA are those specified in s 276 of the Criminal Procedure Act 51 of 1977. As pointed out by the Supreme Court of

[155] Section 1(3)(a)-(d) of the SOA.
[156] *Director of Public Prosecutions, Western Cape v Prins* [2012] ZAWCHC 42 (11 May 2012).
[157] [2012] ZAWCHC 42 (11 May 2012).
[158] *Director of Public Prosecutions, Western Cape v Prins (Minister of Justice and Constitutional Development & two amici curiae intervening)* (369/12) [2012] 106 ZASCA; 2012 (2) SACR 183 (SCA) para 18.
[159] *Director of Public Prosecutions, Western Cape v Prins (Minister of Justice and Constitutional Development & two amici curiae intervening)* (369/12) [2012] 106 ZASCA 2012 (2) SACR 183 (SCA) para 1.
[160] Criminal Law (Sexual Offences and Related Matters) Amendment Act [Bill 19 of 2012].

Appeal, while this Bill still awaits the assent of the President it nonetheless provides a clear example of subsequent legislation constituting a 'legislative declaration' of the meaning parliament wishes to have ascribed to earlier legislation.[161]

Section 28 of the SOA has also been criticised extensively. Section 28 states that a rape survivor exposed to the risk of HIV "may" receive PEP,[162] but goes on to include unnecessary obstacles to the provision of such services and does not contain a broader section relating to the general health care management of survivors of rape. Section 28 of the Act provides for the provision of PEP subject to the condition that the rape survivor lays a charge with the South African Police Services (section 28(2)(a)) or reports an incident in respect of an alleged sexual offence in the "prescribed manner" at a "designated health establishment" (section 28(2)(b)).

There are numerous reasons why a complainant may be afraid or reluctant to report such an offence to the police. For example, a woman who is raped by her intimate partner may be particularly reluctant to report such an offence due to a fear of escalating violence. There may also be socio-economic reasons as to why such women are unable to access a 'designated health establishment.' The reference to 'designated health establishments' also indicates that not all health establishments will offer PEP free of charge. Furthermore, while the SOA allows for survivors of rape to report the incident to a health establishment, many health care providers first send the rape survivor to the police. For example, in the Free State, 83.3 % of health care providers indicated that they would first send the rape complainant to the police, before examining him/her.[163]

Lilian Artz points out that actual access to PEP may be further limited by a lack of knowledge and logistical and institutional barriers,[164] as many police officers and health professionals may not be aware of their specific duties. Her criticism appears warranted, as during an audit in 2008, it was discovered that many of the health establishments

---

[161] *Director of Public Prosecutions, Western Cape v Prins (Minister of Justice and Constitutional Development & two amici curiae intervening)* (369/12) [2012] 106 ZASCA 2012 (2) SACR 183 (SCA) para 37.
[162] Section 28(1) (a) (i) of the SOA.
[163] N Christofides, N Webster, R Jewkes, L Penn-Kekana, L Martin, N Abrahams & J Kim "The State of Sexual Assault Services: Findings from a Situation Analysis" *SAGBVHI Report* (2003) i 16 <http://wiredspace.wits.ac.za/bitstream/handle/10539/3942/M77%20Sexual%20Assault%20Services.pdf?sequence=1.> (accessed 14-07-2012).
[164] Artz (2009) *CME* 466.

listed by police officials in terms of the SOA did not in fact provide PEP.[165] A further obstacle lies in the nature of PEP. As the drugs' effectiveness declines rapidly over time, the victim needs to present at the designated health establishment within 72 hours of the commission of the offence (Section 28 (2) of the Act).

PEP is also only one dimension of adequate care for survivors of rape, with the emotional and psychological needs of survivors of rape effectively ignored by the SOA. This is in spite of a recommendation by the South African Law Reform Commission (hereafter "SALRC") to include a provision providing for State-supplied psychological counselling and support to survivors of sexual offences.[166] The importance of effectively addressing emotional and psychological health care services was illustrated in a study conducted by the Medical Research Council which emphasised the connection between the emotional and psychological consequences of rape and the resultant challenges of accessing PEP. They pointed out that the stigma attached to rape and the stress and fear of possible HIV infection effectively debilitates the ability to take PEP.[167] It has also been pointed out that rape is one of the most pathogenic forms of violence with regard to post traumatic stress disorder.[168] Given the devastating emotional and psychological health consequences of rape, placing the onus on the rape survivor to report the rape in order to access the necessary care is thus unjustifiable.

Section 28(3) of the Act also stipulates that the medical practitioner to whom the sexual offence was reported must inform the complainant of the importance of obtaining PEP for HIV infection within 72 hours. They are also required to point out the importance of obtaining medical advice and assistance regarding the possibility of other sexually transmitted infections. In the case of an application contemplated in section 30, health care providers must hand the complainant a notice containing the prescribed information regarding the compulsory HIV testing of the alleged offender and explain the contents thereof to him or her.

---

[165] Vetten et al "*The Right and the Real*" (2010) 73.
[166] South African Law Reform Commission "Discussion Paper 102 (Project 107) Sexual Offences: Process and Procedure" (2002) 1, 12 <http://www.justice.gov.za/salrc/dpapers/dp102-execsum.pdf> (accessed 04-07-2011).
[167] Abrahams & Jewkes (2010) *Culture, Health & Sexuality* 471.
[168] D Kaminer, A Grimsrud, L Myer, DJ Stein & DR Williams "Risk for Post-traumatic Stress Disorder Associated with Different Forms of Interpersonal Violence in South Africa" (2008) 67 *Social Science & Medicine* 1589 1590.

Section 30 of the Act allows the complainant to have the offender tested for HIV. This right is, however, limited, in that testing must be done within 90 days of the incident, the complainant must apply to a magistrate for the test to be done, and the offence must have been reported and a charge must have been laid. The Act also provides for an investigating officer to apply to a magistrate for an order that the offender be tested for HIV. In order for health care services to be effective, there has to be sufficient awareness among patients of their particular rights. The dissemination of health care policies and appropriate education on the health care rights of women is therefore necessary to ensure accessibility of health care services. In this regard the right to have access to information is included in the Constitution (section 32). In *Minister of Health and Others v Treatment Action Campaign and Others*[169] the Court further held that in order for a health care programme to be optimally implemented it must:

> "[B]e made known effectively to all concerned, down to the district nurse and patients. Indeed, for a public programme such as this to meet the constitutional requirement of reasonableness, its contents must be made known appropriately."[170]

In a study conducted by Gender Links however, it was pointed out that only 36.3% of the study group representing Gauteng even knew about the new SOA.[171] Therefore, many men and women do not even know that they have the right to obtain access to PEP after being raped.

In order to ensure the effective implementation of the SOA, budgetary support is necessary. In this regard, R214 million was allocated by the government, over a period of three years, for the implementation of the Sexual Offences Act.[172] It is unclear however, as to how much of this was allocated to the Department of Health for the provision of health care services. There is also no mention in the Minister of Health's budget speech

[169] 2002 5 SA 703 (CC); 2002 10 BCLR 1075 (CC).
[170] *Minister of Health and Others v Treatment Action Campaign and Others* 2002 (5) SA 703 (CC); 2002 (10) BCLR 1075 (CC) para 123.
[171] M Machisa, R Jewkes, C L Morna & K Rama "Response to Gender-based Violence" in *The War at Home* (2011) <http://www.genderlinks.org.za/article/the-war-at-home---gbv-indicators-project-2011-08-16> (04-05-2012) 89 94.
[172] "The State of the Nation, Government Priorities & Women" 32.

of 2012 for the prioritisation of health care services for SGBV.[173] The focus of this speech was predominantly on targeting maternal mortality and the prevention of mother to child transmission of HIV/AIDS. It is submitted therefore; that in order to effectively implement the SOA greater attention and financial support needs to be provided to the effective health care management of survivors of rape. Furthermore, in order for organisations representing women's rights to further advocate for the specific health care needs of women, greater transparency as to the exact resource allocations made by the State in this regard, is needed.

3 5 3 Relevant health policy addressing sexual violence

Before the democratic era health care services for survivors of rape were provided by district surgeons.[174] Such surgeons were generally private family doctors with little or no special training which often led to secondary victimisation of rape complainants. In 1999 the Minister of Health mandated that all doctors could undertake examinations of survivors of rape. However, there was no simultaneous training or effective planning to support this decision.[175]

In 2000, certain improvements occurred with the introduction of the sexual assault evidence collection kit and the testing of DNA. However, many health care providers have complained that such evidence collection kits are often already used or incomplete when they receive them.[176] The National Prosecuting Authority also introduced the Thuthuzela rape care centres in 2000 in order to provide holistic and coordinated services to rape survivors in one setting.[177] While these units have been heralded as a 'star project',[178] they have suffered from severe implementation problems with such

[173] Minister of Health, Dr Aaron Motsoaledi "Department of Health Budget Vote Speech 2012/13: National Assembly, Cape Town" (2012) <http://www.doh.gov.za/show.php?id=3564> (accessed 05/05/2012).
[174] Christofides et al "The State of Sexual Assault Services: Findings from a Situation Analysis" (2003) 2.
[175] Seedat et al (2009) *The Lancet* 1016.
[176] Christofides et al "The State of Sexual Assault Services" (2003) 14.
[177] The National Prosecuting Authority: The Sexual Offences and Community Affairs Unit "Thuthuzela Care Centres: Turning victims into Survivors" *National Prosecuting Authority News Brochure* (2009) 1-8 3 <http://www.npa.gov.za/UploadedFiles/THUTHUZELA%20Brochure%20New.pdf> (accessed on 15-02-2011).
[178] Vetten et al "*The Right and the Real*" (2010) 3.

services predominantly being provided to children, in spite of the fact that women over the age of 18 are reportedly the main complainants of rape.[179]

In 2003 the National Management Guidelines for Sexual Assault Care[180] was released by the Department of Health and in 2005 the National Sexual Assault Policy[181] was released. Since 2005, services are also provided by district hospitals or community health centres.[182] In 2008 a national curriculum for training health care providers in providing care to survivors of rape was launched, with a predominate focus on the mental and the physical health care needs of survivors of sexual violence. The National Directives and instructions on conducting a forensic examination on survivors of sexual offence cases in terms of the Criminal Law (Sexual Offences and Related Matters) Amendment Act 2007[183] were subsequently released in 2009. These directives are intended to be read with the Department of Health's National Management Guidelines for Sexual Assault Care, and the National Sexual Assault Policy, which provides much more detailed information.

However, despite the fact that the National Sexual Assault Policy attempts to incorporate a holistic approach towards the management of sexual assault, this policy document has been criticised for its erratic and slow implementation.[184] For example, the National Sexual Assault Policy states, under its guiding principles, that health care services should be provided in a non-judgmental manner and that services should always be provided by specialists. However, services for survivors of rape are offered in a variety of settings, from district, regional and tertiary-level hospitals. In some instances rape survivors are tended to in the casualty section of hospitals with staff unable to provide specialised and sensitised care.[185] Rape survivors are also often bypassed for

[179] Vetten et al "*The Right and the Real*" (2010) 3.
[180] Department of Health "National Management Guidelines for Sexual Assault Care" (2003) <http://www.tlac.org.za/wp-content/uploads/2012/01/Sexual-Assault-Guidelines-2003.pdf> (accessed 29-04-2011).
[181] Department of Health "National Sexual Assault Policy" (2005) 1, 1.
[182] Seedat et al (2009) *The Lancet* 1016.
[183] "National Directives and Instructions on Conducting a Forensic Examination on Survivors of Sexual Offence Cases in Terms of the Criminal Law (Sexual Offences and Related Matters) Amendment Act" 2007 Title GN R 223 in *GG* 31957 of 2009-03-06.
[184] L Vetten & T Jacobs "Towards Developing and Strengthening a Comprehensive Response to the Health Care Needs of Rape Survivors" (2008) 1 *Policy Brief* 1 3.
[185] Vetten & Jacobs (2008*) Policy Brief* 3-4.

patients who are more severely physically injured, while being exposed to a stressful environment. There are also persistent complaints that health care workers are judgemental and abusive.[186]

Therefore, while there has been extensive progress, the policy response to rape by the Department of Health remains somewhat fragmented. This fragmented approach prevents complainants from knowing precisely what they are entitled to receive. It also undermines quality control, with health care providers frequently criticised for failing to adhere to health care policy guidelines, consequently resulting in uneven implementation. This has subsequently weakened the health care response to rape in South Africa.

3 5 4 Conclusion

While the new SOA has brought about much needed law reform, certain provisions fall short of the Act's objective to provide rape survivors with "the maximum and least traumatising protection that the law can provide".[187] For example, the lack of provision within the SOA for psychological health care services effectively ignores the traumatising impact of rape, and how it prevents adherence to PEP. There is therefore a need to extend the health care services offered to survivors of rape, while current obstacles in relation to accessing PEP need to be effectively addressed. There is also a need to publicise information, as many complainants of rape are not even aware of the existence of the SOA.

Both the National Sexual Assault Policy and the National Management Guidelines for Sexual Assault Care have faced severe implementation problems, which has effectively served as a barrier to women accessing holistic health care services.[188] Furthermore, given that these documents are unenforceable policy documents, the holistic and patient-centred provisions within them do not give sufficient effect to the constitutional rights of

[186] Vetten & Jacobs (2008*) Policy Brief* 4.
[187] Section 2 of the SOA.
[188] Vetten & Jacobs (2008) *Policy Brief* 3.

rape survivors.[189] It is submitted therefore, that the provisions relating to counselling and mental health care should have been included within the SOA. Health care providers are further failing to adhere to their responsibilities in terms of the SOA, while there is insufficient cooperation between the Department of Justice and the Department of Health.[190]

The Thuthuzela Care Centres are facing their own challenges. Despite the commitment made in the 2011 State of the Nation Address that support would be given to the Thuthuzela Care Centres,[191] none of the ministers in the Justice, Crime Prevention and Security Departments mentioned the Thuthuzela Care Centres in their 2012 budget speeches.[192] The Thuthuzela Care Centres are also suffering from implementation problems, including a lack of awareness of the national guidelines by health care providers, differences in the implementation of services between various sites (as a result of policy fragmentation), the inadequate training and resourcing of care centres which has led to half-hearted services (such as patients not receiving the full 28 day pack of PEP after the starter pack) and inadequate services for patients with special needs.[193] Therefore, while great progress has been made, gaps in the SOA remain, while the fragmented approach to sexual assault policy needs to be effectively addressed.

In order to ensure the effective implementation of the SOA and existing health care policy on rape, budgetary support is necessary. In this regard, the State has been criticised for not making its budgetary allocations to women's specific health care needs available.[194] While there are resource constraints, there is no reason as to why women should have to bear the brunt of such limited resources. The broader health care needs of women and particularly the health care needs of SGBV should therefore receive increased attention and support from the State.

---

[189] Pieterse (2010) *Law, Democracy & Development* 10.
[190] "The State of the Nation, Government Priorities & Women" 3.
[191] See: President Jacob G Zuma *State of the Nation Address By His Excellency Jacob G Zuma, President of the Republic of South Africa, at the Joint Sitting Of Parliament* (2011) 1-22 15 <http://www.parliament.gov.za/live/content.php?Category_ID=337> (accessed 01-03-2011).
[192] "The State of the Nation, Government Priorities & Women" 35.
[193] United Nations Agency International Development South Africa "Final Report on the Compliance Assessment of the Thuthuzela Care Centres with National Department of Health Guidelines for Managing HIV in the Context of Sexual Assault" (2007) 1-80 5-6 <http://pdf.usaid.gov/pdf_docs/PNADT749.pdf> (accessed 12-03-2011).
[194] "The State of the Nation, Government Priorities & Women" 32.

3 6 Conclusion

Despite the constitutional protection of the right to have access to health care services and the right to equality, health care remains inequitable and inefficient in South Africa. If we use Nancy Fraser's "politics of need interpretation" approach we are able to see that there is a significant gap in recognising the broader health care needs of women and particularly the needs of SGBV. Such an analysis also reveals the extensive and varied problems that exist in relation to the effective implementation of existing rights.

In relation to the NHA, great progress was made in recognising the plight of the poor by mandating the provision of free primary health care services for certain vulnerable groups. The NHA also recognises the particular vulnerability of women and children. However, the NHA fails to provide any recognition of the epidemics of domestic violence and rape, in spite of the fact that these epidemics disproportionately affect such vulnerable groups. The lack of any concrete provisions aimed at ameliorating the reality of GBV further exacerbates the existing gap in health care services for SGBV.

In relation to the implementation of the NHA, the fact that many people who qualify for free health care services fail to receive such services is problematic. The dismal quality of health care services, the lack of sufficient health clinics within rural areas and the discriminatory attitudes of health care providers in public health establishments, further undermines the goal of equal access to quality health care services. While containing certain admirable provisions, the NHA is therefore insufficiently responsive to the realities of gender-based disadvantage within our society.

In relation to the proposed NHI system, this system does have the potential to facilitate access to health care services for more South Africans. It has the additional potential of alleviating the burden of caring work that is placed on many poor women. The State has also allocated additional resources for the effective implementation of the NHI, illustrating political support.[195] However, the policy paper on the NHI system does

[195] According to the National Treasury:

not provide any focus on services for SGBV, with no mention of domestic violence and human trafficking. The success of the NHI will therefore depend on how the NHI is implemented and whether women's needs are further integrated into the NHI policy document. [196]

In relation to health care services for survivors of domestic violence, the lack of duties placed upon the Department of Health is problematic and effectively prevents the development and monitoring of national health standards in this regard. It has the additional problem of exacerbating legal uncertainty as to the Department of Health's responsibilities in addressing domestic violence. The fragmented nature of services that are provided to survivors of domestic violence [197] is further problematic as it lacks coherence and needs to be consolidated.

In relation to the SOA, the Act goes a long way in transforming rape policy and legislation. However, it stops short of recognising the holistic health care needs of survivors of rape, despite the fact that rape is an epidemic in South Africa with strong links to the spread of HIV/AIDS. The legislature therefore failed to recognise the substantial health care needs of survivors of sexual assault. The provisions within the SOA that effectively hamper access to PEP therefore need to be addressed.

According to Jennifer Nedelsky the law will always "respond to and reflect culture as well as have the capacity to shift relations within it."[198] Legislation and policy should therefore guide health care providers on how to recognise and adequately respond to the nature of GBV, in a manner that respects the dignity, autonomy and agency of women. Health care providers will therefore need to be trained on the complex social reality of GBV, and on the human rights of SGBV.

"The Department of Health receives the biggest additional allocations for health and social protection. The department receives R1 billion over the next three years for the national health insurance pilot projects and increases in primary health care visits."

See: National Treasury "Estimate of National Expenditure" (2012) v http://www.treasury.gov.za/documents/national%20budget/2012/ene/FullENE.pdf> (accessed 04-05-2012).

[196] R Amollo "The National Health Insurance Policy: What's in it for Women's Health in South Africa?" (2012) 92 *Agenda* 111 122.

[197] L Vetton "Outlining the Rationale for a Health Sector Response to Domestic Violence" in Tshwaranang Legal Advocacy Centre to Violence against Women, Centre for Health Policy & School of Public Health *Developing a Health Sector Response to Domestic Violence: A Roundtable Discussion* (2008) 1-32 5 <http://www.tlac.org.za/images/documents/TLAC_Roundtable_web.pdf> (accessed 04-03-2011).

[198] Nedelsky "Violence against Women in Nedelsky *Law's Relations* 204.

It is clear that in order for health care policies to be effectively implemented, the State needs to provide affirmative institutional and financial support for the realisation of such programmes.[199] A proactive response is further necessary due to the entrenched and systemic nature of gender inequality in South Africa. While the State has expressed its commitment to addressing GBV and gender inequality, State support has been criticised for being uncoordinated and difficult to access.[200] Given that the State expresses its commitment to gender equality through its allocation of resources to issues which predominantly affect women, this is problematic.[201] Of particular concern is the lack of transparency in relation to the allocation of resources to women's particular health care needs.

The right to have access to health care services therefore needs to be translated into comprehensive and consolidated health care programmes that are tailored to respond to the reality of gender inequality and GBV in South Africa.[202] Such programmes also need to receive adequate financial and institutional support in order to facilitate their effective implementation. This approach is required if we are to truly protect the constitutional rights of women in South Africa. It is therefore clear that health legislation and policy in South Africa can be more gender-sensitive. The next chapter will consider the extent to which relevant international and regional human rights instruments can assist in broadening access to health care services, while improving the gender-sensitivity of such services for SGBV.

[199] Nussbaum (2003) *Feminist Economics* 38.
[200] D Budlender & J Kuhn (Centre for the Study of Violence and Reconciliation) "Where is the Money to Address Gender-Based Violence?" (2007) 1 4.
[201] D Budlender "The Political Economy of Women's Budgets in the South" (2000) 28 *World Development* 1365 1368.
[202] S Fredman "Engendering Socio-Economic Rights" (2009) 25 *SAJHR* 410 411.

4 The role of international law in developing the normative content of the right to have access to health care services

4 1 Introduction

This chapter examines the role of international law in developing the scope of the constitutional right to have access to health care services, including reproductive health care, for survivors of gender-based violence (hereafter "GBV").[1] Such an analysis is necessary as GBV is a brutal form of gender discrimination[2] that both reflects and reinforces existing systemic inequalities for women.[3] GBV is also a leading cause of death and disability for women.[4] Health care services therefore need to be strengthened in order to mitigate the consequences of GBV and possibly prevent its escalation.[5]

This chapter therefore analyses the development of the international right to the highest attainable standard of health, with a particular focus on article 12 of the International Covenant on Economic, Social and Cultural Rights.[6] This will be followed by an analysis of the Convention on the Elimination of All Forms of Discrimination against Women,[7] (hereafter "CEDAW") which has assisted in developing the normative content of the international right to health, with a particular focus on women.[8]

Relevant regional instruments such as the African Charter on Human and People's Rights[9] and the Protocol to the African Charter on the Rights of Women in Africa[10]

---

[1] Section 27(1)(a) of the Constitution of the Republic of South Africa, 1996.

[2] United Nations Committee on the Convention on the Elimination of Discrimination against Women, General Recommendation No 19 *Violence against Women* (1992) (article 3 of the Convention) UN Doc A/47/38 para1 states:

> **"**Gender-based violence is a form of discrimination that seriously inhibits women's ability to enjoy rights and freedoms on a basis of equality with men."

[3] *S v Baloyi* 2000 2 SA 425 (CC); 2000 1 SACR 81 (CC) para 12.

[4] M Seedat, A Van Niekerk, R Jewkes, S Suffla & K Ratele "Violence and Injuries in South Africa: Prioritising an Agenda for Prevention" (2009) 374 *The Lancet* 1011 1011; B Meyersfeld *Domestic Violence and International Law* (2011) 1.

[5] B Meyersfeld "Domestic Violence, Health, and International Law" (2008) 22 *Emory International Law Review* 61 112.

[6] International Covenant on Economic, Social, and Cultural Rights (1966) UN Doc A/6316 (hereafter "ICESCR").

[7] Convention on the Elimination of All Forms of Discrimination against Women (1977) UN Doc A/34/46, (hereafter "CEDAW").

[8] C Ngwena & R Cook "Rights Concerning Health" in D Brand and C Heyns (eds) *Socio Economic Rights in South Africa* (2005) 107 120.

[9] African Charter on Human and Peoples' Rights (1981) OAU Doc CAB/LEG/67/rev.5.

[10] Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (2000) CAB/LEG/66.6.

will also be analysed, in addition to relevant 'non-binding' international law. Non-binding international law includes declarations, codes of practice, statements by Special Rapporteurs and resolutions of the General Assembly which are not meant to be ratified.[11]

General Recommendation 19 by the Committee on the Elimination of Discrimination against Women (hereafter the "CEDAW Committee")[12] will also be considered, as this Recommendation has developed the right to non-discrimination under article 1 of CEDAW to include GBV.[13] General Recommendation 19 has also incorporated a reference to the "due diligence"[14] standard to determine what diligent States should do to protect women from violence.[15]

An analysis of international law is valuable as it can serve as a tool to enunciate human rights standards, while highlighting certain deficiencies in a domestic legal system.[16] Through analysing relevant international law this chapter will therefore consider the degree to which South Africa is adhering to international standards in providing health care services to survivors of GBV (hereafter "SGBV").

4 2 International law in South Africa

[11] E de Wet "The "Friendly but Cautious" Reception of International Law in the Jurisprudence of the South African Constitutional Court: Some Critical Remarks" (2005) 28 *Fordham International Law Journal* 1529 1534-1535.

[12] United Nations Committee on the Convention on the Elimination of Discrimination against Women, General Recommendation No 19 *Violence against Women* paragraph 6 (1992) (article 9 of the Convention) UN Doc A/47/38 (hereafter "General Recommendation 19").

[13] General Recommendation No 19 para 9.

[14] The due diligence concept refers to a State's duty to prevent private acts of violence. In the seventeenth century jurists referred to it as the obligation of the sovereign to prevent injury to foreign nationals and their property by private individuals and to ensure that reparations were paid where damages were perpetrated. The concept was first used for the protection of human rights in the 1970's in relation to forced disappearances in Latin America. In the case of *Velsquez Rodriguez Case, 1988 Inter-American Court on Human Rights (ser. C) No. 4 (July 29,)* the Inter-American Court of Human Rights found that Honduras had failed to fulfil its obligations in terms of article 1(1) of the American Convention of Human Rights and stated that:

> "States have a legal duty to take reasonable steps to prevent human rights violations and to use the means at its disposal to carry out a serious investigation of violations committed within its jurisdiction, to identify those responsible, to impose the appropriate punishment and to ensure the victim adequate compensation." (para 174).

See: J A Hessbrugge "The Historical Development of the Doctrines of Attribution and Due Diligence in International Law" (2003) 36 *New York University Journal of International Law and Politics* 265 256-257; 275; See also J Bourke-Martignoni "The History and Development of the Due Diligence Standard in International Law" in C Benninger-Budel (ed) *Due Diligence and Its Application to Protect Women from Violence* (2008) 47 48-50.

[15] Typically due diligence requires the drafting of legislation, the provision of adequate services and the allocation of sufficient resources for the effective implementation of such laws See: Meyersfeld *Domestic Violence* 151.

[16] Meyersfeld *Domestic Violence* xxxiv.

Prior to 1993, international law was insufficiently utilised by the South African courts in advancing human rights in South Africa.[17] This reality was significantly changed by the adoption of section 35(1) of the interim Constitution.[18] After a slight change in the wording, section 35(1) later became section 39(1) (b) of the final Constitution.[19] Section 39(1)(b) specifically mandates that the courts 'must consider' international law when interpreting the Bill of Rights. The broad description of 'international law' in section 39(1)(b) means that South African courts are able to consider all sources of international law as recognised under article 38(1) of the Statute of the International Court of Justice.[20] These sources include: international treaties and conventions, customary international law, general principles of law as recognised by civilised nations and legal jurisprudence. [21] Resolutions and declarations by United Nation bodies and officials are increasingly being recognised as evidence of international law,[22] and may also be considered by the courts.

While the courts are empowered to consider a broad array of international instruments when interpreting the Bill of Rights, it is important to bear in mind that not all of these international legal sources are necessarily binding in South Africa.[23] In relation to the binding nature of treaties, South Africa follows the pre-1994 dualist approach.[24] The Constitution specifically states that the negotiation and signing of

---

[17] J Dugard "The Role of International Law in Interpreting the Bill of Rights" (1994) 10 *SAJHR* 208 208; H Combrinck "Positive State Duties to Protect Women from Violence: Recent South African Developments" (1998) 20 *Human Rights Quarterly* 666 671.

[18] The Constitution of the Republic of South Africa, Act 200 of 1993.

[19] The Constitution of the Republic of South Africa, 1996 (hereafter "the Constitution").

[20] Dugard (1994) *SAJHR* 212.

[21] Article 38 (1) of the Statute of the International Court of Justice states:

"The Court, whose function is to decide in accordance with international law such disputes as are submitted to it, shall apply:

a. International conventions, whether general or particular, establishing rules expressly recognized by the contesting states;

b. international custom, as evidence of a general practice accepted as law;

c. the general principles of law recognized by civilised nations;

d. subject to the provisions of Article 59, judicial decisions and the teachings of the most highly qualified publicists of the various nations, as subsidiary means for the determination of rules of law."

[22] Meyersfeld *Domestic Violence* 3-4.

[23] J Dugard "Sources of International Law" in *International Law: A South African Perspective* (2007) 27 29; S Liebenberg *Socio-Economic Rights Adjudication under a Transformative Constitution* (2010) 103, where she states:

"International law that is binding on South Africa includes primarily treaties to which it is a State party as well as norms of customary international law".

[24] Traditionally, there have been two theoretical approaches to international law in South Africa. The first approach has been referred to as the monist approach which perceives international law and municipal law as part of a single conception of law. The second approach has been referred to as the dualist approach which is based on the premise that international law and municipal law are separate entities. Under the dualist theory international law is only applicable after a two-stage approach. For example, a treaty only becomes part of South African law after being signed by the executive and then incorporated into legislation by the legislature. See: Dugard *International Law* 47.

treaties is the responsibility of the executive,[25] and that signed international treaties are binding within the Republic after approval in parliament.[26] However, international treaties only become part of South African law after being enacted into law by an Act of Parliament, thus requiring a two-stage process.[27]

An administrative, technical or executive international agreement, or an agreement which does not require ratification or accession, and which is entered into by the national executive, also binds the Republic,[28] but must be tabled in the National Assembly and the National Council of Provinces within a reasonable amount of time.

A self-executing provision of an agreement is also law, unless it is inconsistent with the Constitution or an Act of Parliament.[29] A 'self-executing provision' is difficult to define and has been the subject of some controversy.[30] However, it has mainly been thought to be a provision within a treaty that is directly applicable without the need to be incorporated through legislation.[31]

In relation to customary international law, South Africa follows the monist approach in that customary international law is law in South Africa, unless it is inconsistent with the Constitution or an Act of Parliament.[32] The constitutional openness to international law is made even clearer through section 233 of the Constitution, which provides that when interpreting any domestic legislation, every court must prefer any reasonable interpretation that is consistent with international law.[33] The courts

[25] Section 231 (1) of the Constitution states: "The negotiating and signing of all international agreements is the responsibility of the national executive."

[26] Section 231(2) of the Constitution states:
"An international agreement binds the Republic only after it has been approved by resolution in both the National Assembly and the National Council of Provinces, unless it is an agreement referred to in subsection (3)."

[27] Dugard *International Law* 58-59.

[28] Section 231(3) of the Constitution states:
"An international agreement of a technical, administrative or executive nature, or an agreement which does not require either ratification or accession, entered into by the national executive, binds the Republic without approval by the National Assembly and the National Council of Provinces, but must be tabled in the Assembly and the Council within a reasonable time."

[29] Section 231(4) of the Constitution states:
"Any international agreement becomes law in the Republic when it is enacted into law by national legislation; but a self-executing provision of an agreement that has been approved by Parliament is law in the Republic unless it is inconsistent with the Constitution or an Act of Parliament."

[30] Liebenberg *Socio-Economic Rights* 103.

[31] Dugard *International Law* 62; Liebenberg *Socio-Economic Rights* 103.

[32] Section 232 of the Constitution.

[33] Section 233 of the Constitution states that:
"When interpreting any legislation, every court must prefer any reasonable interpretation of the legislation that is consistent with international law over any alternative interpretation that is inconsistent with international law."

have however been criticised for severely neglecting this provision as an interpretive tool.[34]

While the courts have also been criticised for inconsistently applying 'non-binding' international law,[35] in *S v Makwanyane and Another*,[36] the Constitutional Court adopted a broad interpretive approach to international law, making it clear that both binding and non-binding international law may play a role in interpreting the Bill of Rights. For example, the Court stated that:

> "In the context of section 35(1), public international law would include non- binding as well as binding law. They may both be used under the section as tools of interpretation. International agreements and customary international law accordingly provide a framework within which Chapter Three can be evaluated and understood, and for that purpose, decisions of tribunals dealing with comparable instruments, such as the United Nations Committee on Human Rights, the Inter-American Commission on Human Rights, the Inter-American Court of Human Rights, the European Commission on Human Rights, and the European Court of Human Rights, and in appropriate cases, reports of specialised agencies such as the International Labour Organisation may provide guidance as to the correct interpretation of particular provisions of Chapter Three."[37]

It is therefore clear that international law can play a valuable role when interpreting and developing the Bill of Rights. For example, a deeper engagement with both binding and non-binding international law in the adjudication of the constitutional rights can promote a jurisprudence that is more receptive to the persuasive force of legal arguments under international law.[38] This approach is thus able to engender new ways of understanding and interpreting these rights which consequently supports a more transformative jurisprudence.[39] The international understanding of the right to the highest attainable standard of health may therefore assist in broadening the normative content of the right to have access to health care services, including reproductive health care, in South Africa.[40] An analysis of the development of this international right is therefore necessary.

---

[34] L Du Plessis "Beyond Parochialism? Transnational Contextualisation in Constitutional Interpretation in South Africa: With Particular Reference to Jurisprudence of the Constitutional Court" in M Faure (ed) *Globalisation and Private Law: the Way Forward* (2010) 145 147.
[35] De Wet (2005) *Fordham International Law Journal* 1534-1535.
[36] *S v Makwanyane and Another* 1995 2 SACR 1; 1995 6 BCLR 665; [1995] ZACC 3.
[37] *S v Makwanyane and Another* 1995 2 SACR 1; 1995 6 BCLR 665; [1995] ZACC 3 paragraph 35.
[38] S Liebenberg *Socio-Economic Rights* 101.
[39] S Liebenberg *Socio-Economic Rights* 102.
[40] Meyersfeld *Domestic Violence* (2010) xxxiv.

4 3 Development of the right to the highest attainable standard of health in international law

4 3 1 Introduction

Traditionally, ill-health was considered to be a sign of poor spiritual worth, or simply divine will.[41] However, through the development of the natural sciences, the link between the underlying determinants of health and illness was developed. This eventually led to good health being recognised as indispensable for the exercise of other fundamental human rights and intricately interlinked to human dignity.[42] Thus, one of the first articulations of the 'right to health' in international law was the broad description contained in the 1946 Constitution of the World Health Organisation:

> "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition."[43]

This definition has been criticised for being too broad, in that no State government can ever truly ensure complete well-being.[44] While it has also been criticised for being too vague, such a broad definition does highlight that human health means more than simply accessing medication and health care services.

Further development of the meaning of the right to health occurred in 1948, with the adoption of the Universal Declaration of Human Rights[45] (hereafter the "UDHR"). This instrument reflected the growing international appreciation of the need to protect fundamental human rights, particularly after the horrors that were perpetrated during

[41] R J Cook "International Human Rights and Women's Reproductive Health" (1993) 24 *Studies in Family Planning* 73 73.
[42] D M Chirwa "Implications for the Obligations of State and Non-State Actors in Ensuring Access to Essential Medicine" (2003) 19 *SAJHR* 541 543.
[43] World Health Organisation *Constitution of the World Health Organisation*, adopted by the International Health Conference on 22 July 1946, opened for signature on 22 July 1946 and entered into force on 7 April 1948 <http://www.who.int/governance/eb/who_constitution_en.pdf> (accessed 12-04-2012).
[44] M Pieterse *A Benefit-Focused Analysis of Constitutional Health Rights* DPhil dissertation University of Witwatersrand (2005) 25.
[45] Universal Declaration of Human Rights (1948) U.N. Doc A/810 at 71 (hereafter the "UDHR").

the Second World War. While the status of the UDHR is rather contentious,[46] this instrument does contain a number of provisions that relate to equality and health. For example, article 1 states that all human beings are born free and equal in dignity and rights, while article 2 states that 'everyone' is entitled to the rights in the UDHR without distinction of any kind. In relation to health, article 25 states that:

> "(1) Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control."

The UDHR also recognises the particular needs of mothers by stating that: "Motherhood and childhood are entitled to special care and assistance."[47] The right to health was further developed and recognised in various international treaties, including the Standard Minimum Rules for the Treatment of Prisoners (1955)[48] and the Convention on the Elimination of all Forms of Racial Discrimination (1965).[49]

During the 1960's, the rights in the UDHR were subsequently developed into international human rights treaties. This was done pre-eminently through the International Covenant on Civil and Political Rights[50] (hereafter the "ICCPR") and the International Covenant on Economic, Social and Cultural Rights [51] (hereafter "ICESCR"), which were both adopted in 1966.[52] South Africa signed the ICCPR in 1994 and ratified it in 1998. While South Africa signed the ICESCR in October of 1994, it has to date, failed to ratify this treaty. In relation to the protection of the international right to health, the ICESCR is of particular importance as this Covenant recognises that everyone has the right to the highest attainable standard of physical and mental health.[53]

---

[46] Dugard *International Law* 315.
[47] Article 16 of the UDHR.
[48] Standard Minimum Rules for the Treatment of Prisoners (1955), U.N. Doc. A/CONF/611 articles 22-26 and article 82.
[49] Convention on the Elimination of all Forms of Racial Discrimination (1965) 660 UNTS 195 article 5(e)(iv).
[50] International Covenant on Civil and Political Rights (1966) 999 UNTS 171.
[51] International Covenant on Economic, Social and Cultural Rights (1966) 993 UNTS 3.
[52] Chirwa (2003) *SAJHR* 545.
[53] Article 12 of ICESCR.

CEDAW, which is discussed in detail later on, also specifically recognises the right to health for women.[54] South Africa signed CEDAW in 1993 and ratified it in 1995. The Convention Concerning Indigenous and Tribal Peoples in Independent Countries[55] and the Convention on the Rights of the Child[56] also specifically recognise the right to health. The importance of the right to health is therefore recognised in an array of international instruments. While these treaties have assisted in developing the normative content of the right to health, article 12 of the ICESCR is the most authoritative articulation of health as a human right under international law.

4 3 2 The International Covenant on Economic, Social and Cultural Rights

Despite the fact that South Africa has to date, failed to ratify the ICESCR, this Covenant has particular significance in South African law. For example, the Technical Committee that was responsible for assisting in drafting the Constitution specifically recommended the inclusion of socio-economic rights after analysing international law instruments, including the ICESCR.[57] Consequently, the drafting of sections 26 and 27 of the Constitution were broadly modelled on article 2 of ICESCR.[58] Thus, both the Constitution and the ICESCR[59] refer to the requirement of 'progressive realisation' when implementing the relevant right, in addition to the limitation of 'available resources'. In this regard, the Technical Committee specifically pointed out that by including provisions similar to article 2 of ICESCR, this would facilitate consistency between South Africa's domestic policies and laws and international human rights law.[60] These similarities therefore facilitate reliance upon international law when interpreting section 27 of the Constitution. In the case of *Government of the*

[54] Article 12 of CEDAW.
[55] Convention Concerning Indigenous and Tribal Peoples in Independent Countries (1989) 1650 UNTS 383 article 25.
[56] Convention on the Rights of the Child (1989) 1577 UNTS 3 article 24.
[57] Liebenberg *Socio-Economic Rights* 17.
[58] Pieterse *A Benefit-Focused Analysis of Constitutional Health Rights* DPhil dissertation University of Witwatersrand (2005) 49; Liebenberg *Socio-Economic Rights* 19.
[59] Article 2.1 of the ICESCR states that:
"Each State Party to the present Covenant undertakes to take steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant by all appropriate means, including particularly the adoption of legislative measures."
[60] Liebenberg *Socio-Economic Rights* 19.

Republic of South Africa v Grootboom and Others,[61] the Constitutional Court further confirmed that relevant international law can be a guide to interpreting the socio-economic rights. However, the Court held that the weight to be attached to any particular principle or rule of international law will vary. [62] In the case of *Governing Body of the Juma Musjid Primary School & Others v Essay N.O. and Others*[63], the Court discussed the content of the right to education in the context of an application to evict a public school conducted on private property. In interpreting the right to education, the Court referred to the protection of this right in international law,[64] while specifically referencing the ICESCR and General Comment 13. [65] The Court specifically highlighted the importance of this right in our democratic dispensation in relation to both international law and South Africa's legacy of apartheid.[66] Ultimately the Court confirmed that the right to education as contained in section 29(1)(a) of the Constitution is immediately realisable.[67] This case therefore reveals that international law can play a valuable role in developing interpretations of the socio-economic rights.

Further similarities between ICESCR and the Constitution include the protection of the right to equality. ICESCR specifically recognises the right to non-discrimination[68] and the right to equal enjoyment by men and women of all economic, social and cultural rights.[69] Likewise, section 9 of the Constitution prohibits unfair discrimination and states that equality includes the full and equal enjoyment of all rights and

[61] *Government of the Republic of South Africa v Grootboom* 2001 1 SA 46 (CC); 2000 11 BCLR 1169 (CC).
[62] *Government of the Republic of South Africa v Grootboom* 2001 1 SA 46 (CC); 2000 11 BCLR 1169 (CC) para 26.
[63] [2011] ZACC 13; 2011 8 BCLR 761 (CC) (11 April 2011).
[64] *Governing Body of the Juma Musjid Primary School & Others v Essay N.O. and Others* [2011] ZACC 13; 2011 8 BCLR 761 (CC) (11 April 2011) paras 35; 40-41.
[65] *Governing Body of the Juma Musjid Primary School & Others v Essay N.O. and Others* [2011] ZACC 13; 2011 8 BCLR 761 (CC) (11 April 2011) para 41. See: United Nations Committee on Economic, Social and Cultural Rights, General Comment No 13 *The Right to Education,* (1999) (article 13 of the Covenant) UN Doc E/C.12/1999/10.
[66] *Governing Body of the Juma Musjid Primary School & Others v Essay N.O. and Others* [2011] ZACC 13; 2011 8 BCLR 761 (CC) (11 April 2011):

> "The significance of education, in particular basic education for individual and societal development in our democratic dispensation in the light of the legacy of apartheid, cannot be overlooked. The inadequacy of schooling facilities, particularly for many blacks was entrenched by the formal institution of apartheid, after 1948, when segregation even in education and schools in South Africa was codified. Today, the lasting effects of the educational segregation of apartheid are discernible in the systemic problems of inadequate facilities and the discrepancy in the level of basic education for the majority of learners. Indeed, basic education is an important socio-economic right directed, among other things, at promoting and developing a child's personality, talents and mental and physical abilities to his or her fullest potential." (Paras 42-43).

[67] *Governing Body of the Juma Musjid Primary School & Others v Essay N.O. and Others* [2011] ZACC 13; 2011 8 BCLR 761 (CC) (11 April 2011) para 37.
[68] Article 2(2) of ICESCR.
[69] Article 3 of ICESCR.

freedoms in the Constitution.[70] In relation to health care, article 10(2) of ICESCR refers to the 'special protection' that should be accorded to mothers during a reasonable period before and after childbirth. The most prominent protection of health is however, in article 12(1) of ICESCR which states that States Parties that have ratified the ICESCR are obliged to:

> "Recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health."[71]

Article 12 (2) goes on to describe the (non-exhaustive)[72] steps that need to be taken by the States Parties to the ICESCR in order to achieve the full realisation of this right. Such steps include the reduction of the stillbirth-rate and of infant mortality while facilitating the healthy development of the child.[73] It also entails improving all aspects of environmental and industrial hygiene,[74] while providing for the prevention, treatment and control of epidemic, endemic, occupational and other diseases.[75] Article 12 also mandates the creation of conditions which would assure to all medical service and medical attention in the event of sickness.[76]

Article 12 does not specifically refer to women's health care. However, given the health consequences of GBV, the requirements of article 12(2)(c) may require increased efforts to prevent, treat and control gendered diseases, such as the HIV/AIDS epidemic. The requirement that all members of a society should have access to medical attention[77] also highlights an equality dimension to the right to the highest attainable standard of health.

The human rights treaty body responsible for monitoring the implementation of the ICESCR (the United Nations Committee on Economic, Social and Cultural Rights (hereafter "UNESCR")) has provided clarification on their interpretation of the rights in ICESCR in the form of General Comments. General Comments 14[78] has thus

---

[70] Section 9(2) of the Constitution.
[71] Article 12(1) of the ICESCR.
[72] United Nations Committee on Economic, Social and Cultural Rights, General Comment No 14 *The right to the highest attainable standard of health*, (2000) (article 12 of the Covenant) UN Doc E/C.12/2000/4 paragraph 7.
[73] Article 12(2)(a) of ICESCR.
[74] Article 12(2)(b) of ICESCR.
[75] Article 12(2)(c) of ICESCR.
[76] Article 12(2)(d) of ICESCR.
[77] Article 12(2)(d) of ICESCR.
[78] United Nations Committee on Economic, Social and Cultural Rights, General Comment No 14 *The right to the highest attainable standard of health*, (2000) (article 12 of the Covenant) UN Doc E/C.12/2000/4 (hereafter "General Comment No 14").

elaborated on the content of article 12 of ICESCR. General Comment 16[79] has also elaborated on the equal right of men and women to enjoy the socio-economic rights. While these General Comments are not legally binding, they do carry persuasive weight as they are indicative of the manner in which the primary supervisory body of the ICESCR interprets these provisions. [80] These General Comments can thus be viewed as authoritative interpretations of these rights that effectively contribute to the normative understanding of the international right to health.

4 3 3 General Comment 14 on the Right to the Highest Attainable Standard of Health

While ICESCR recognises the right to the highest attainable standard of physical and mental health as a basic human right, General Comment 14 elaborates on the meaning of the right, in addition to the particular standards that health care services and goods need to adhere to.

The General Comment first points out that the right to health is indispensable for the exercise of other human rights,[81] and that everyone is entitled to enjoy a standard of health conducive to living a life of dignity. In defining the constitutive elements of article 12, the General Comment points out that article 12 does not entail a right to be healthy. In contrast, article 12 includes a right to a package of interrelated human entitlements and freedoms that facilitate the opportunity to attain the highest standard of physical and mental health that an individual can achieve.[82] Therefore, article 12 embraces a wide range of socio-economic factors that promote health, such as food and nutrition, housing, access to safe and potable water and adequate sanitation, healthy working conditions, and a healthy environment.[83]

In terms of entitlements, General Comment 14 mandates the existence of an adequate health care system which provides equality of opportunity[84] for people to enjoy the highest attainable level of health. In this regard the General Comment goes

[79] United Nations Committee on Economic, Social and Cultural Rights, General Comment No 16 *The equal right of men and women to the enjoyment of all economic, social and cultural rights*, (2005) (article 3 of the Covenant) UN Doc E/C.12/2005/4 (hereafter "General Comment No 16").
[80] Liebenberg *Socio-Economic Rights* 107.
[81] General Comment No 14, para 1.
[82] General Comment No 14, para 8.
[83] General Comment No 14, paras 4 and 11.
[84] General Comment No 14, para 8.

on to provide that health care services need to be available, accessible, acceptable and of a decent quality.[85]

In terms of availability, health care facilities need to be functioning and available in sufficient quantity. The Committee has pointed out that this requirement of availability also applies to the underlying determinants of health, such as safe and potable drinking water, adequate sanitation facilities and adequate hospitals and clinics.[86]

Accessibility of health care services has three dimensions, comprising physical accessibility, economic accessibility and access to information. The General Comment states that health facilities, goods and services have to be accessible to everyone without discrimination. This has implications for the most vulnerable members of a society, such as rural women.[87]

In terms of the acceptability of health care services, health facilities, goods and services should be respectful of medical ethics and culturally appropriate and sensitive. This should include sensitivity to gender and life-cycle requirements, as well as being designed to respect confidentiality.[88]

In relation to the quality of health care services, such services must be culturally acceptable and scientifically and medically appropriate. This requires the availability of skilled medical personnel, scientifically approved drugs and sufficient hospital equipment. It also entails access to safe and potable water, and adequate sanitation.[89] In this regard, UNESCR has specifically pointed out that the quality dimension of the right to health is an essential element of the international right to health.[90]

These international standards highlight aspects of the international right to health that are of particular concern to South Africa. For example, the escalation of private health care costs[91] and the rise in maternal mortality,[92] illustrates that access to quality health care services is currently restricted for many South Africans. Given the

[85] General Comment No 14, paras 12(a)-12(d).
[86] General Comment No 14, para 12(a).
[87] General Comment No 14, para 12(b).
[88] General Comment No 14, para 12(c).
[89] General Comment No 14, para 12(d).
[90] General Comment No 14, para 12(d).
[91] Department of Health "National Health Insurance in South Africa Policy Paper" (2011) 10 paragraph 27 <http://www.info.gov.za/view/DownloadFileAction?id=148470> (accessed 11-08-2011). This policy paper pointed out that the costs of private hospital care have also increased by 121% over the past decade alone.
[92] According to Human Rights Watch maternal mortality has more than quadrupled within South Africa from 150 deaths per 100,000 live births in 1998 to 650 deaths per 100,000 in 2007. See: Human Rights Watch "Maternal Mortality in South Africa and Eastern Cape" in *Stop Making Excuses: Accountability for Maternal Health Care in South Africa* (2011) 1 19 <http://www.hrw.org/node/100757> (accessed 14-07-2011.)

dismal state of the South African public health care system, as highlighted in chapter three,[93] the obligation to progressively realise the constitutional right to have access to health care services therefore necessarily entails a duty to improve the nature and the quality of the health care services that are provided.[94]

In terms of health-related freedoms, women should be able to exercise control over their own body, including sexual and reproductive freedom. This right also includes the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and experimentation.

The General Comment goes on to elaborate on the interrelationship between the right to non-discrimination and the right to health,[95] in addition to the health care needs of women.[96] The General Comment states that equality of access to health care services needs to be emphasised and that States have a special obligation to provide those who do not have sufficient means to access health care services with the necessary health insurance and health care facilities that they require.[97] The General Comment further points out that inappropriate resource allocation can lead to discrimination that is not necessarily overt.[98] With regard to the need to introduce health insurance, South Africa has released a policy paper on the proposed National Health Insurance system (hereafter "NHI"), which is discussed in detail in chapter three.[99] However, while the NHI system has great potential to extend access to health care services to more South Africans, it has been criticised for failing to address the particular health care needs of women.[100]

In relation to the scope of the right to health, the General Comment points out that the provision for the reduction of the stillbirth rate and of infant mortality[101] may be understood as requiring measures to improve maternal health. This provision may also require the improvement of sexual and reproductive health services, including access to family planning, emergency obstetric services and access to information.

In relation to gender equality, the General Comment points out that States need to engender their health-related policies, planning, programmes and research in order

[93] For a detailed discussion on the problems facing the South African public health care system see chapter three, pages 50-51.
[94] Liebenberg *Socio-Economic Rights* 188.
[95] General Comment No 14,paras 3, 12(b) and 18.
[96] General Comment No 14, para 20.
[97] General Comment No 14, para 19.
[98] General Comment No 14, para 19.
[99] See chapter three, pages 60-63.
[100] R Amollo "The National Health Insurance Policy: What's in it for Women's Health in South Africa?" (2012) 92 *Agenda* 111 122.
[101] Article 12(2)(a) of ICESCR.

to promote better health for women.[102] The General Comment specifically highlights that in order to eliminate discrimination against women; there is a need to develop a comprehensive national strategy to promote women's health throughout their lifespan. The Committee elaborates, in the following terms, on the scope of this strategy:

> "Such a strategy should include interventions aimed at the prevention and treatment of diseases affecting women, as well as policies to provide access to a full range of high quality and affordable health care, including sexual and reproductive services. A major goal should be reducing women's health risks, particularly lowering rates of maternal mortality and protecting women from domestic violence. The realisation of women's right to health requires the removal of all barriers interfering with access to health services, education and information, including in the area of sexual and reproductive health."[103]

In relation to the specific steps that States must take, General Comment 14 refers to the tripartite typology of interdependent duties,[104] which entails duties to respect, protect and fulfil all human rights. General Comment 14 states that the obligation to respect requires States to refrain from interfering directly or indirectly with the enjoyment of the right to health. The obligation to protect entails preventing third parties from interfering with the right, while the obligation to fulfil requires States to adopt appropriate legislative, budgetary and judicial measures to facilitate the realisation of the right to health. In relation to judicial measures to facilitate the realisation of the socio-economic rights, the South African judiciary has focused on the needs of vulnerable groups when deciding socio-economic cases.[105] However, given the extreme imbalance between the public and private health care systems in South Africa, there is a need for a more robust analysis of the State's responsibilities to address this inequality. International law standards can thus be used to bolster a more critical scrutiny of government's defence of 'a lack of available resources' in failing to adequately address this imbalance.

The tripartite typologies of duties are mirrored in section 7 of the Constitution, which states that: "the state must respect, protect, promote and fulfil the rights in the

[102] General Comment No 14, para 20.
[103] General Comment No 14, para 21.
[104] The tripartite typology of interdependent duties was first referred to by Henry Shue. See: H Shue "Correlative Duties" in H Shue *Basic Rights: Subsistence, Affluence, and U.S. Foreign Policy* (1996) 35 52.
[105] In *Government of the Republic of South Africa v Grootboom* 2001 1 SA 46 (CC); 2000 11 BCLR 1169 (CC), the Court found that the government's housing policy was unreasonable, mainly because it did not provide relief for people in desperate need (para 69).

Bill of Rights." While the Constitutional Court has not openly relied on this tripartite typology of duties, the Court has recognised that civil and political rights, in addition to social and economic rights can, in certain contexts, entail both positive and negative duties.[106] These obligations may thus serve as factors to consider in determining whether government conduct is reasonable.

General Comment 14 elaborates further on the duties of States by stating that States have a 'minimum core'[107] obligation to ensure the satisfaction of, minimum essential levels of each of the rights enunciated in the ICESCR, including essential primary health care.[108] General Comment 14 goes on to state that this minimum core obligation entails ensuring access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalised groups. While the reference to minimum core obligations does highlight particularly important duties in relation to the most vulnerable members of a society, the minimum core approach has also been criticised.[109] While a detailed analysis of the minimum core is beyond the scope of this chapter, it is important to note that the South African Constitutional Court has not endorsed the minimum core approach, despite substantial criticism.[110] The Court has however stated that the minimum core may play a role in determining what is reasonable, when evaluating government's health care policies and programmes.[111]

The international conception of 'progressive realisation' can also aid interpretations of section 27 of the Constitution. For example, General Comment 3 on the nature of States Parties' obligations states that the notion of progressive realisation imposes an obligation to move as expeditiously and effectively as possible towards realisation of a particular right.[112]

General Comment 14 thus highlights the interdependence of the right to equality and the right to health, with a particular focus on the needs of vulnerable groups. This General Comment also specifically highlights the need to take proactive and positive

---

[106] Liebenberg *Socio-Economic Rights* 86.
[107] The 'minimum core' was a concept first developed by the United Nations Committee on Economic, Social and Cultural Rights in General Comment No 3 *The nature of State parties' obligations*, (1990) (article 2 para 1 of the Covenant) UN Doc 1990/12/14 (hereafter "general comment 3").
[108] General Comment No 14, para 43.
[109] The minimum core has been criticised in that it may encourage minimalism while excluding those who's immediate survival needs are not infringed. See: A Sen *Inequality Re-examined* (1995) 115.
[110] D Bilchitz "Giving Socio-Economic Rights Teeth: The Minimum Core and its Importance" (2002) 119 *SALJ* 484 486.
[111] *Government of the Republic of South Africa v Grootboom* 2001 1 SA 46 (CC); 2000 11 BCLR 1169 (CC) para 33; *Minister of Health and Others v Treatment Action Campaign* (No 2) 2002 5 SA 721 (CC), 2002 10 BCLR 1033 (CC) para 34.
[112] General Comment No 3, para 9.

steps to address inequality in accessing health care and to move as expeditiously as possible while doing so. General Comment 14 further supports the development of a comprehensive health care policy to address gender discrimination, while highlighting the need to take legislative and budgetary steps to support and facilitate the realisation of such a programme.

4 3 4 General Comment 16 on the Equal Right of Men and Women to the Enjoyment of All Economic, Social and Cultural Rights

General Comment 16 concerns the equal right of men and women to the enjoyment of all economic, social and cultural rights. General comment 16 specifically points out that gender-neutral policies can perpetuate inequality by failing to take into account the existing economic, social and cultural inequalities, experienced by women.[113] States are thus enjoined to recognise the specific gendered inequalities experienced by women and to adopt special measures in favour of women, in order to attenuate conditions that perpetuate discrimination.[114] Read together with General Comment 14, States are thus required to develop positive health care interventions that effectively alleviate socio-economic disadvantage for women.

In regard to the obligation to protect the socio-economic rights, States are obliged to take steps to eliminate prejudices, customary and all other practices that perpetuate the notion of inferiority of either of the sexes.[115] States are further required to remove the legal and other obstacles that prevent women from accessing health care services on a basis of equality.[116] Given the entrenched negative attitudes of many South African health care workers, this General Comment highlights the need to take positive steps to adequately train health care providers.

In relation to GBV, General Comment 16 specifically refers to the duty to provide for rehabilitation and prevention programmes in order to ensure that women enjoy their socio-economic rights.[117] It also requires States to design and implement

[113] General Comment No 16, para 8.
[114] General Comment No 16, para 15.
[115] General Comment No 16, para 19.
[116] General Comment No 16, para 29.
[117] General Comment No 16, para 21.

policies to give long-term effect to the equal enjoyment of socio-economic rights, while recognising that this may entail gender-specific allocations of resources.[118]

With a particular reference to domestic violence, General Comment 16 requires that States must provide victims of such violence with access to safe housing in addition to redress for physical, mental and emotional damage.[119] Paragraph 27 of General Comment 16, read with General Comment 14 thus requires the extension of current health care interventions for survivors of domestic violence to include access to shelter and appropriate psychological care.

4 3 5 Montreal Principles on Women's Economic, Social and Cultural Rights

The Montreal Principles on Women's Economic, Social and Cultural Rights[120] (hereafter "the Montreal principles") are an example of non-binding international law. These principles do however point out important aspects of socio-economic rights as they relate to women. For example, the Montreal principles point out that acknowledging the systemic and entrenched discrimination that women have experienced, is an essential step in implementing international guarantees of non-discrimination and equality.[121] In this regard, the Montreal principles recognise that the feminisation of poverty is a central manifestation, and a direct result of women's lesser social, economic and political power.[122] The Montreal principles further recognise that women's poverty reinforces their subordination, and constrains their enjoyment of every other right.[123] This poverty further makes such women more vulnerable to human trafficking, violence and ill health. This raises the need for States to address the underlying issue of gender inequality and to actively promote the social, economic and cultural rights of women in order to protect them from exploitation and abuse.

---

[118] General Comment No 16, para 21.
[119] General Comment No 16, para 27.
[120] International Federation for Human Rights, *Montreal Principles on Women's Economic, Social and Cultural Rights* (2002)
[121] International Federation for Human Rights, *Montreal Principles on Women's Economic, Social and Cultural Rights* (2002) 1.
[122] International Federation for Human Rights, *Montreal Principles on Women's Economic, Social and Cultural Rights* (2002) 2.
[123] International Federation for Human Rights, *Montreal Principles on Women's Economic, Social and Cultural Rights* (2002) 2.

The Montreal principles go on to state that States are required to repeal laws and policies that discriminate either directly or indirectly against women.[124] In this regard, South Africa should remove current obstacles that prevent survivors of rape from accessing post-exposure prophylaxis (hereafter "PEP").

The Montreal principles therefore support a substantive approach to equality, focusing on the need to take positive steps to alleviate the subordination, stereotyping and structural disadvantage that many women experience.[125] The Montreal principles further stress that the steps undertaken must be grounded in women's actual lived realities.[126]

4 3 6 General Comment 20: Non-discrimination in Economic, Social and Cultural Rights

General Comment 20[127] specifically highlights that non-discrimination and equality are fundamental components of international human rights law and that these rights are essential for the exercise and enjoyment of economic, social and cultural rights.[128] General Comment 20 further highlights the need for States to prioritise the needs of women and children, referring to article 10 of ICESCR which stipulates that, mothers should be accorded special protection during a reasonable period before and after childbirth.[129]

This General Comment defines non- discrimination as an immediate and cross-cutting obligation in the Covenant.[130] Discrimination is also defined broadly as any distinction, exclusion, restriction, preference or differential treatment that is directly or indirectly based on the prohibited grounds of discrimination, perpetrated with the intention or effect of nullifying or impairing the recognition, enjoyment or exercise, on an equal footing, of Covenant rights.[131] General Comment 20 specifically recognises

---

[124] International Federation for Human Rights, *Montreal Principles on Women's Economic, Social and Cultural Rights* (2002) 11.
[125] International Federation for Human Rights, *Montreal Principles on Women's Economic, Social and Cultural Rights* (2002) 4.
[126] International Federation for Human Rights, *Montreal Principles on Women's Economic, Social and Cultural Rights* (2002) 9.
[127] United Nations Committee on Economic, Social and Cultural Rights, General Comment No 20 *Non-discrimination in economic, social and cultural rights* (2009) (article 2, para 2, of the Covenant) UN Doc E/C.12/GC/20 (hereafter "General Comment No 20"), para 2.
[128] General Comment 20, para 2.
[129] General Comment 20, para 4.
[130] General Comment 20, para 7.
[131] General Comment 20, para 7.

the need for substantive equality, [132] while highlighting that in certain cases States will need to adopt special measures in order to attenuate discrimination.[133] States are thus required to take concrete, deliberate and targeted measures to eliminate discrimination.[134] Individuals and groups of individuals who may be distinguished by one or more of the prohibited grounds should also be ensured the right to participate in decision making processes over the selection of such measures. [135] General Comment 20 goes on to point out that this will need to be coupled with the necessary budgetary allocations in order to ensure the effective implementation of such measures. This is emphasised in light of the obligation to guarantee the effective enjoyment of the Covenant rights without discrimination.[136]

4 3 7 Conclusion: Obligations under international law

International law supports a substantive approach to equality in providing access to health care services. For example, as an immediate obligation, General Comment 14 requires that States provide access to health facilities, goods and services on a non-discriminatory basis. General Comment 14 elaborates on this duty, emphasising the obligation to take concrete positive steps to provide health insurance and health care services to those who cannot afford to pay for such services. In this regard South Africa's policy paper on the NHI system is promising. However, as pointed out in General Comment 14, in order to promote better health for women, health care programmes such as the NHI policy paper need to be 'engendered'.[137] The NHI system therefore needs to be infused with the broader health care needs of women.

In relation to the jurisprudence on socio-economic rights, there is a need for an increased focus on the interrelationship between the right to equality and the right to have access to health care services. International law standards can thus be used to bolster a more critical scrutiny of government's defence of 'a lack of available resources' in failing to adequately address this inequality.

The emphasis on quality of health care services as an integral component of the right to health in General Comment 14, can also bolster claims against the State to progressively improve the quality of health care services that are provided. The

[132] General Comment 20, para 8(b).
[133] General Comment 20, para 9.
[134] General Comment 20, para 36.
[135] General Comment 20, para 36.
[136] General Comment 20, para 38.
[137] General Comment No 14, para 20.

principles of availability, accessibility, acceptability and of quality as highlighted in General Comment 14, can play an additional role in guiding the specific areas that need to be improved within South Africa's public health care system. For example, the State needs to address the human resources crisis that is currently plaguing the public health care system. As gate-keepers to the health care system, health care providers also need to receive gender-sensitivity training in order to enhance access to health care services. In this manner, international law can thus be used to enhance accountability for the current failings within our public health care system.

General Comment 14, General Comment 16 and the Montreal principles highlight that States need to remove the gendered obstacles that prevent women from accessing appropriate health care services. This includes improving access to adequate transport and removing current obstacles that impair access to PEP. General Comment 16 and the Montreal principles further highlight the need for States to recognise the systemic and entrenched nature of gender inequality, while General Comment 20 provides that States are required to take concrete, deliberate and targeted measures to eliminate such discrimination.[138] In this regard it is argued that South Africa needs to develop a comprehensive health care programme that recognises the systemic and entrenched nature of GBV, in addition to a more holistic conception of GBV. South Africa will also need to introduce particular health care interventions tailored to the different forms of GBV, such as providing shelter and psychological health care services for survivors of domestic violence. In accordance with General Comment 20, States should furthermore facilitate a participatory process in allowing women to shape the particular health care services that they would prefer to receive. This should be coupled with the necessary budgetary allocations.[139]

The tripartite typology of interdependent duties that are highlighted in General Comment 14;[140] further specify the need to take appropriate legislative, budgetary and judicial measures to facilitate the realisation of the right to health and to support such measures. In this manner, international law could be used as a tool to enhance

[138] General Comment 20, para 36.
[139] General Comment 20, para 36.
[140] The tripartite typology of interdependent duties was first referred to by Henry Shue. See: H Shue *Basic Rights: Subsistence, Affluence, and U.S. Foreign Policy* (1996) 52.

accountability of health care policy makers and to extend current health care programmes to include the specific needs of abused women.[141]

While General Comment 14, General Comment 16, the Montreal principles and General Comment 20 refer to women's particular health care needs, there has also been development under the CEDAW Convention and the subsequent General Recommendations that have been released by the CEDAW Committee. It is thus important to analyse the relevant provisions of CEDAW in addition to these General Recommendations.

4 4 Development of a gender-sensitive interpretation of the right to health

4 4 1 Introduction

Despite appearing gender-neutral on the surface, it has been argued that both the structures of international law-making and the content of the rules of international law have privileged men.[142] The international legal system has thus been criticised for being a thoroughly gendered system.[143] This is partly due to the fact that the structure of international relations has been based on the notion of the liberal social contract. This social contract has also been criticised for establishing the public/private law divide,[144] a concept which was discussed in detail in chapter two.[145] This divide effectively led to 'public violence', such as torture, traditionally being recognised as a violation of human rights, while 'private violence,' such as domestic violence, was not. For example, despite article 9 of the 1966 ICCPR stating that 'everyone' has the right to liberty and security of the person, before 1994 rape committed during conflict was not prosecuted as a breach of humanitarian law or the

[141] While the Constitutional Court did not endorse the minimum core approach in *Minister of Health v Treatment Action Campaign* (No 2) 2002 5 SA 721 (CC), the Court did order the government to remove the restrictions that prevented nevirapine from being made available at public hospitals and clinics (para 135). See: G Sen, P Östlin & A George "Unequal, Unfair, Ineffective and Inefficient Gender Inequity in Health: Why it Exists and How We Can Change It" (2007) 1 94 <http://www.who.int/social_determinants/resources/csdh_media/wgekn_final_report_07.pdf> (accessed 12-06-2012).

[142] H Charlesworth, C Chinkin & S Wright "Feminist Approaches to International Law" (1991) 85 *American Journal of International Law* 613 615.

[143] Charlesworth et al (1991) *American Journal of International Law* 615.

[144] C Romany "Women as Aliens: A Feminist Critique of the Public/Private Distinction in International Human Rights Law" (1993) 6 *Harvard Human Rights Journa*l 87 89.

[145] See chapter 2, pages 33-34.

laws of war.[146] It was only in 1998 in the case of *Prosecutor v Akayesu*[147] that the International Criminal Tribunal for Rwanda changed this reality. In this case, the criminal tribunal tried and convicted an individual for crimes against humanity and genocide for facilitating the mass rape of women. Violence within the private sphere, such as domestic violence was even more neglected under international law.[148] As further pointed out by Rhonda Copelon:

> "The number of its [Gender-based violence] victims exceeds those of war and the most brutal dictatorships of our time. And yet, to speak of it as a violation of women's human rights has been, until recently, treated as absurd or heretical. The egregiousness of gender-based violence has been matched only by its absence from human rights discourse."[149]

The lack of prosecution of GBV under international law thus highlights the failings of a gender-neutral approach.[150] This led feminists to argue that, given the particular harm and discrimination that women have experienced, there was a particular need for gender-sensitive rights.[151] This ultimately culminated in the adoption of CEDAW.

4 4 2 The Convention on the Elimination of all forms of Discrimination against Women

In 1979, the Convention on the Elimination of all Forms of Discrimination against Women (CEDAW) was adopted. CEDAW is often referred to as the Bill of Rights for women and has been hailed for its progressive recognition of both substantive equality and justiciable socio-economic rights.[152] In relation to its recognition of equality, CEDAW recognises the particular nature of discrimination that women have

[146] Meyersfeld *Domestic Violence* 92-93; U O'Hare "Realising Human Rights for Women" (1999) 21 *Human Rights Quarterly* 364 369.
[147] International Criminal Tribunal for Rwanda *Prosecutor v Akayesu* Case No. ICTR-96-4-T.
[148] O'Hare (1999) *Human Rights Quarterly* 369.
[149] R Copelon "Recognizing the Egregious in the Everyday: Domestic violence as Torture" (1994) 25 *Columbia Human Rights Law Review* 291 292.
[150] Cook (1993) *Human Rights Quarterly* 251.
[151] R Cook "Women's International Human Rights Law: The Way Forward" (1993) 15 *Human Rights Quarterly* 230 239.
[152] S Fredman "Engendering Socio-Economic Rights" (2009) 25 *SAJHR* 410 434.

experienced as a group.[153] Article 1 of CEDAW thus contains a broad description of discrimination as:[154]

> "Any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field."

Article 2 requires that states must pursue by all appropriate means and without delay a policy of eliminating such discrimination against women. CEDAW also seeks to ensure structural change with article 5 providing that States must take measures to:

> "Modify 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 the superiority of either of the sexes or on stereotyped roles for men and women".

Many academics have thus praised the cultural, political and legal significance of CEDAW.[155] Of particular importance is CEDAW's recognition of positive obligations to realise equality, not only providing for legal equality but also equality in factual context.[156] CEDAW also effectively undermines the public/private law divide by requiring that States accord women and men equality before the law in terms of both public and private law.[157] Despite CEDAW's significance however, the only provision in CEDAW that actually refers to specific forms of violence against women is article 6 which prohibits human trafficking, in addition to the exploitation of sex workers.

---

[153] Cook (1993) *Human Rights Quarterly* 240.
[154] "The Convention goes beyond the concept of discrimination used in many national and international legal standards and norms. While such standards and norms prohibit discrimination on the grounds of sex and protect both men and women from treatment based on arbitrary, unfair and/or unjustifiable distinctions, the Convention focuses on discrimination against women, emphasizing that women have suffered, and continue to suffer from various forms of discrimination because they are women." United Nations Committee on the Elimination of Discrimination against Women General Recommendation No 25: *On Temporary Special Measures* (2000) (article 4, paragraph 1 of the Convention), para 5.
[155] A Bayefsky "The CEDAW Convention: It's Contribution Today" (2000) 94 *Proceedings of the Annual Meeting (American Society of International Law)* 197 197.
[156] Bayefsky (2000) *Proceedings of the Annual Meeting (American Society of International Law)* 197.
[157] Article 15 of CEDAW.

CEDAW thus refrains from categorising violence against women as a human rights issue in its operative provisions,[158] an issue which has garnered some criticism.[159]

4 4 3 International recognition of GBV and the introduction of the due diligence standard

Since the 1980's, there have been various developments that have remedied this omission in CEDAW, resulting in numerous forms of GBV being recognised by the CEDAW Committee. For example, in 1989 the CEDAW Committee addressed violence against women at its eighth session by adopting General Recommendation 12 on violence against women.[160] The Recommendation specifically requires that States protect women from:

> "Violence of any kind occurring within the family, at the workplace or in any other area of social life."

Further development resulted in the adoption of General Recommendation 19 by the CEDAW Committee in 1992. General Recommendation 19 is noteworthy for expanding the jurisdiction of the CEDAW Committee to include GBV, with paragraph 6 stating that the definition of discrimination in CEDAW includes:

> "Gender-based violence, that is, violence that is directed against a woman because she is a woman or that affects women disproportionately. It includes acts that inflict physical, mental or sexual harm or suffering, threats of such acts, coercion and other deprivations of liberty."

General Recommendation 19 further recognised the severe harm that such violence inflicts. For example, this Recommendation recognises family violence as one of the most insidious forms of violence against women. This Recommendation further states that the abrogation by men of their family responsibilities can also be a

---

[158] H Charlesworth "Feminist Methods in International Law" (1999) 93 *American Journal of International Law* 379 382.

[159] According to Hilary Charlesworth: "Its effect is to blot out the experiences of many women and to silence their voices in international law." See: Charlesworth (1999) *American Journal of International Law* 383.

[160] United Nations Committee on the Elimination of Discrimination against Women, General Recommendation No 12 *Violence against Women* (1989) (article 1 of the Convention) U.N. Doc. A/44/38 (hereafter "General Recommendation 12").

form of violence against women.[161] The Recommendation goes on to state that these forms of violence put women's health at risk while impairing their ability to participate in family life and public life on a basis of equality.[162]

General Recommendation 19 also provides useful guidelines and standards to be adopted by States Parties in addressing GBV. For example, it incorporates the due diligence standard, specifically stating that States may be liable for private acts of violence if they fail to exercise due diligence in preventing violations of rights or in investigating and punishing acts of violence or in providing compensation.[163]

In 2006, the Special Rapporteur on Violence against Women (Professor Yakin Erturk) released a report titled "The Due Diligence Standard as a Tool for the Elimination of Violence against Women".[164] Under her discussion of the due diligence obligation of protection she specified that States are required to ensure that women and girls who are victims of violence, or at risk of violence, have access to health care and support services that respond to their immediate needs, protect them against further harm and continue to address the on-going consequences of violence.[165] In her discussion on compensation, she went on to state that States are also required to ensure that women victims of violence have access to appropriate rehabilitation and support services.[166]

It is clear that adequate health care services have the potential to repair some of the physical and psychological damage caused by GBV. It is submitted therefore, that South Africa has a legal responsibility to take reasonable steps to prevent GBV and to provide reparation to SGBV in the form of appropriate gender-sensitive health care services.

Given that all of forms of GBV require an adequate health care response, it is also important to evaluate how the CEDAW Committee has developed the normative content of the right to the highest attainable standard of health in relation to SGBV.

4 4 4 Development of the normative content of the right to the highest attainable standard of health for women

[161] General Recommendation 19, para 23.
[162] General Recommendation 19, para 23.
[163] General recommendation 19, para 9.
[164] Y Ertürk, United Nations Special Rapporteur on Violence against Women "The Due Diligence Standard as a Tool for the Elimination of Violence against Women: Report of the Special Rapporteur on Violence against Women, Its Causes and Consequences" (2006) UN E/CN.4/2006/61 (hereafter "The 2006 Report of the Special rapporteur on Violence against Women").
[165] The 2006 Report of the Special rapporteur on Violence against Women, para 82.
[166] The 2006 Report of the Special rapporteur on Violence against Women, para 84.

Article 10(h) of CEDAW provides that States should ensure that women have access to educational information to help ensure the health and well-being of their family. Article 11(1)(f) goes on to provide for the right to healthy working conditions, particularly in relation to reproduction. Of particular importance however, is article 12(1) of CEDAW, which provides that States shall take appropriate measures to eliminate discrimination against women in the field of health care. This is to ensure, on a basis of equality of men and women, that women have access to health care services, including those related to family planning. Article 12(2) goes on to state that States shall ensure women have access to appropriate services in connection with pregnancy, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation. Article 14(b) focuses specifically on rural women and states that States must ensure that rural women have access to adequate health care facilities, including information, counselling and services in family planning.

4 4 5 General Recommendation 19 on Violence against Women

General Recommendation 19 recognises that GBV puts women's health and lives at risk,[167] and that such violence impairs women's enjoyment of the right to the highest attainable standard of physical and mental health.[168] It also states that States Parties are required to take measures to ensure equal access to health care in terms of article 12 of CEDAW. General Recommendation 19 thus recommends that States should take steps to effectively combat GBV and ensure that laws against such violence adequately protect women, while respecting their dignity and autonomy.[169] It also recommends that States provide appropriate supportive services which are complemented by gender-sensitivity training of necessary officials.[170] Similarly, the General Recommendation mandates the establishment of services for victims of family violence, rape, sexual assault and other forms of GBV. Specific services that are included are establishing places of refuge, specially training health workers, and providing rehabilitation and counselling services.[171] States Parties are further enjoined to ensure that measures are taken to prevent coercion in regard to fertility

[167] General Recommendation 19, para 19.
[168] General Recommendation 19, para 7(g).
[169] General Recommendation 19,para 24(a).
[170] General Recommendation 19,para 24(b).
[171] General Recommendation 19,para 24(k).

and reproduction[172] and to ensure that services are accessible to rural women.[173] This last requirement has implications for South Africa, as there is still an insufficient number of health care clinics in rural areas.

This Recommendation specifically highlights steps that need to be taken to combat domestic violence and includes services to ensure the safety and security of complainants of domestic violence, such as the provision of shelters, counselling and rehabilitation programmes.[174] This further justifies the need for specific health care interventions for survivors of domestic violence in South Africa.

4 4 6 The Declaration on the Elimination of Violence against Women

In 1994, the Declaration on the Elimination of Violence against Women [175] (hereafter "DEVAW"), was adopted. Paragraph 4(g) of DEVAW requires States to take steps to ensure that women subjected to violence and, where appropriate, their children have specialised assistance. DEVAW goes on to specifically require the provision of rehabilitation, assistance in child care and maintenance, treatment, counselling, and health and social services, facilities and programmes, as well as support structures. DEVAW further requires that States should take all other appropriate measures to promote their safety and physical and psychological rehabilitation. In addition, DEVAW highlights the need to take measures to ensure that law enforcement officers and public officials responsible for implementing policies to prevent, investigate and punish violence against women receive training to sensitise them to the needs of women.

4 4 7 General Recommendation 24 on the Right to Health

In 2008 the CEDAW Committee adopted General Recommendation 24 on the right to health.[176] In paragraph 5, the CEDAW Committee refers to violence against women as an issue integral to full compliance with article 12 of CEDAW. The General Recommendation also highlights how socio-economic factors can impact upon

[172] General Recommendation 19,para 24(m).
[173] General Recommendation 19,para 24(o).
[174] General Recommendation 19, para r(iii).
[175] United Nations General Assembly Declaration on the Elimination of Violence against Women (1993) UN Doc A/RES/48/104 (hereafter "DEVAW").
[176] United Nations Committee on the Elimination of Discrimination against Women, General Recommendation No 24 *Women and Health* (1999) (article 12 of the Convention), UN Doc A/ 54/38/Rev.1 (hereafter "General Recommendation 24").

women's health. For example, the Recommendation highlights how unequal power relationships between women and men lead to women being exposed to different forms of violence which negatively impacts upon their health.[177]

Paragraph 13 refers to the tripartite typology of interdependent duties. Article 12 of CEDAW thus implies an obligation to respect, protect and fulfil women's rights to health care. In this regard States Parties have the responsibility to ensure that legislation; executive action and policy are infused with these three obligations.

Paragraph 15 of General Recommendation 24 is particularly important as it refers to GBV as a critical health issue, effectively linking the importance of taking steps to protect women from GBV to the right to health. It has been pointed out, that by linking GBV to a mainstream issue such as health, the right to be free from GBV is brought within mainstream political discourse, thus undermining the traditional focus on such violence as 'private'.[178] Paragraph 15 goes on to lay down specific duties in this regard, stating that State Parties should ensure the formulation of health care policies and hospital procedures to address violence against women and children and to provide appropriate health services. Paragraph 15 also requires the training of health care workers to sensitise them and to ensure that they are able to detect and manage the health consequences of GBV. Paragraph 15 further requires the establishment of fair procedures for hearing complaints and imposing appropriate sanctions on health care professionals guilty of sexual abuse of women patients.

Furthermore, article 16 states that States Parties should ensure that adequate health services, including trauma treatment and counselling, are provided for women in especially difficult circumstances.

4 4 8 The Optional Protocol under CEDAW and subsequent jurisprudence

In 2000 the CEDAW Committee adopted the Optional Protocol to CEDAW (hereafter the "Optional protocol"), and in 2005 South Africa ratified it. The Optional protocol enables the CEDAW Committee to receive and consider communications submitted by or on behalf of individuals or groups of individuals, under the jurisdiction of a State Party, claiming to be victims of a violation of any of the rights set forth in the Convention.[179] It also gives the CEDAW Committee investigative powers.[180]

[177] General Recommendation 24, para 12(b).
[178] Meyersfeld *Domestic Violence* 149.
[179] Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women (2000) UN Doc A/54/49, articles 1 & 2.

While there is provision for urgent relief in certain cases, so as to avoid irreparable harm, [181] generally an individual complaint can only be submitted after the complainant has exhausted local remedies within her domestic legal system.

While the CEDAW Committee has decided many cases on violence against women, it has yet to decide a case that predominantly focuses on the interdependence of the right to be free from GBV and the right to the highest attainable standard of health.

In 2004 however, the CEDAW Committee considered a case that concerned the forced sterilization of a Hungarian woman in *Ms A. S. v Hungary*.[182] In this case, the CEDAW Committee took note of the fact that within only 17 minutes, the complainant had entered the hospital, signed a consent form and been operated on. They also took note of the complainant's poor state of health when she entered the hospital and that the word sterilisation was written in a language which the complainant did not understand. The Committee thus found that within those 17 minutes it was not possible for hospital staff to have informed her of all her rights in a manner in which she would have understood.[183] In relation to the human rights of the complainant, the CEDAW Committee stated that compulsory sterilisation adversely affects women's physical and mental health, while infringing upon the right of women to decide on the number and spacing of their children. Accordingly, the CEDAW Committee found that Hungary had violated the complainants rights under articles 10 (h)(the right to have access to specific educational information in relation to family planning), 12 (the obligation to eliminate discrimination against women in accessing health care) and 16 (1) (e) of the Convention (the obligation to eliminate discrimination in relation to family matters).

The CEDAW Committee therefore advised Hungary to take further measures to ensure that the relevant provisions of CEDAW were adhered to by all relevant personnel in public and private health centres. Hungary was also advised to review its legislation to ensure that it conformed to international human rights standards. This case is of particular importance for South Africa, as a recent South African research report has highlighted the high prevalence of discrimination against HIV-

---

[180] Meyersfeld *Domestic Violence* 22.
[181] Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women (2000) UN Doc A/54/49, article 5.
[182] United Nations Committee on the Elimination of Discrimination against Women *Ms A. S. v Hungary* (Communication number 4/2004) Reference No: CEDAW/C/36/D/4/2004.
[183] United Nations Committee on the Elimination of Discrimination against Women *Ms A. S. v Hungary* (Communication number 4/2004) Reference No: CEDAW/C/36/D/4/2004, para 11.3.

positive women by health care workers. The study specifically referred to the case of an HIV-positive pregnant woman who had been forcibly sterilised.[184]

The CEDAW Committee has also found private parties in Austria guilty for failing to adhere to the due diligence standard to protect women from domestic violence, in *Goekce (deceased) v Austria*.[185] In this case, the Vienna Intervention Centre against Domestic Violence submitted a complaint to CEDAW on behalf of Sahide Goekce, who had been murdered by her husband. The first reported incidence of violence occurred in 1999, with the violence escalating over a period of three years. In 2002, an interim injunction was obtained against Mustafa, which forbade him from returning to the family apartment. However, Mustafa simply disobeyed the injunction, and in December of 2002, he shot and killed the deceased, in front of their two daughters. Just the night before the deceased had phoned the police asking for assistance.

This case was important in revealing the delicate balance that needs to be struck between protecting women from violence through the provision of services, and the need to respect and protect their autonomy and agency. While the case must have been frustrating for the Austrian authorities, in that the deceased did not wish to testify against her husband, the case does highlight the unique and often torturous nature of domestic violence. This case also reveals the often futile nature of protection orders, if they are not supported by effective enforcement. Ultimately the CEDAW Committee found that despite the progressive legislative framework that existed in Austria, the system was not supported by the State's agents, a problem that South Africa also suffers from.[186] The CEDAW committee elaborated that:

> "In order for the individual woman victim of domestic violence to enjoy the practical realisation of the principle of equality of men and women and of her human rights and fundamental freedoms, the political will that is expressed in the aforementioned comprehensive system of Austria must be supported by State actors, who adhere to the State party's due diligence obligations."[187]

Austria was thus found to be accountable for failing to exercise the due diligence standard in protecting women from violence. The CEDAW Committee thus advised

[184] Nath "We were Never meant to Survive" (2012) 43.
[185] United Nations Committee on the Elimination of Discrimination against Women *Goekce (deceased) v Austria* (Communication No. 6/2005) Reference No: CEDAW/C/39/D/5/2005.
[186] L Artz "Policing the Domestic Violence Act: Teething Troubles or System Failure" (2001) 47 *Agenda* 4 9.
[187] United Nations Committee on the Elimination of Discrimination against Women *Goekce (deceased) v Austria* (Communication No. 6/2005) Reference No: CEDAW/C/39/D/5/2005, para 12.1.2.

Austria to strengthen implementation and monitoring of the Federal Act for the Protection against Violence within the Family, by acting with due diligence to prevent and respond to such violence against women.[188] Austria was also advised to ensure enhanced coordination among law enforcement and judicial officers and to strengthen training programmes and education on domestic violence.

In 2008 the CEDAW Committee considered women's rights to health in terms of maternal mortality in the decision of *Alyne v Brazil*.[189] Brazil, like South Africa, has disproportionately high maternal mortality rates. Certain vulnerable groups such as indigenous and low-income women (such as the applicant was) are particularly affected. In this case a 28-year-old Brazilian woman named Alyne died from complications resulting from her pregnancy. After being misdiagnosed Alyne was forced to wait in a critical condition for eight hours before an ambulance collected her. Ultimately the CEDAW Committee found that Brazil had violated its obligations under article 12 (in relation to access to health care services), article 2(c) (in relation to access to justice) and article 2(e) (in relation to States Parties due diligence obligations to take all appropriate measures to eliminate discrimination against women by any person, organisation or enterprise) of CEDAW. This case illustrates that States Parties therefore have a due diligence obligation to take measures to ensure that women are able to access health care services on an equal basis.

4 4 9 The CEDAW Committee's recommendations to South Africa

Under article 18 of CEDAW, States undertake to submit reports to the Secretary-General on the legislative, judicial, administrative or other measures that they have adopted in order to implement CEDAW. States are required to submit a report within a year after the CEDAW's entry into force and then at least every four years thereafter. The CEDAW Committee can also request a report from a State. After consideration of such reports the CEDAW Committee may issue concluding observations or recommendations. After considering the combined second, third and

[188] United Nations Committee on the Elimination of Discrimination against Women *Goekce (deceased) v Austria* (Communication No. 6/2005) Reference No: CEDAW/C/39/D/5/2005, para 12.3 (a).
[189] United Nations Committee on the Elimination of Discrimination against Women *Alyne v Brazil* (Communication 17/2008) Reference No: CEDAW/C/49/D/17/2008.

fourth periodic reports of South Africa, the CEDAW Committee provided concluding observations on certain issues in 2011.[190]

Specific concerns that were raised by the CEDAW Committee in relation to GBV included the institutional weakness of the national machinery in addressing gender issues in South Africa, as well as the increasing levels of GBV.[191] The CEDAW Committee specifically advised South Africa to establish mechanisms to facilitate accountability for the effective implementation of the provisions in the Domestic Violence Act 116 of 1998 and the Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007.[192] It further advised South Africa to allocate the necessary resources for the effective implementation of social support services for SGBV.[193]

In relation to health care, the Committee noted the high levels of maternal mortality, in addition to the lack of information on measures aimed at addressing violence against women as a cause of HIV/AIDS.[194] The Committee thus specifically called for the implementation of the Maternal Child and Women's Health Strategy[195] and for the development of policies that address the intersection between GBV and HIV/AIDS.[196] In relation to corrective rapes, the CEDAW Committee advised South Africa to enact a comprehensive piece of anti-discrimination legislation that specifically proscribes multiple forms of discrimination against women on all grounds, including sexual orientation.[197] This once again highlights the need for an official recognition of a more holistic conception of GBV within South Africa.

4 4 10 Conclusion

In accordance with the due diligence rule, South Africa has a legal responsibility to take reasonable steps to prevent and respond to GBV against women.[198] Part of

[190] United Nations Committee on the Elimination of Discrimination against Women "Concluding observations of the Committee on the Elimination of Discrimination against Women to South Africa" (2011) UN Doc CEDAW/C/ZAF/CO/4 paragraph 12 and paragraph 16 (hereafter "concluding observations").
[191] Concluding observations, para 24.
[192] Concluding observations, para 25.
[193] Concluding observations, para 25(d).
[194] Concluding observations, para 35.
[195] Concluding observations, para 36(a).
[196] Concluding observations, para 36(d).
[197] Concluding observations, para 40.
[198] General recommendation 19, para 9; United Nations Committee on the Elimination of Discrimination against Women *Goekce (deceased) v Austria* (Communication No. 6/2005) Reference No: CEDAW/C/39/D/5/2005, para 12.3 (a).

these reasonable steps involves ensuring that complainants receive adequate reparation in the form of accessible and available health care services. States should also ensure that women have access to such services on an equal basis. As abused women are more likely to utilise health care services than criminal justice services, the health care sector is furthermore, a strategic point to effectively identify SGBV while providing rehabilitative care.

Specific steps that South Africa is required to take is the adoption of specific legislation, the development of awareness-raising campaigns and the provision of training for specified professional groups.[199] In this regard, the CEDAW Committee has recommended that South Africa implement existing health care policies, such as the Maternal Child and Women's Health Strategy [200] while introducing a comprehensive piece of anti-discrimination health care policy that recognises and provides services for all forms of GBV.[201] In accordance with this comprehensive policy, the State then needs to develop specific health care interventions for specific forms of GBV. This is supported by General Recommendation 19 and General Recommendation 24 by the CEDAW Committee, in addition to DEVAW. For example, it is recommended that States provide the necessary services for victims of family violence, rape, sexual assault and other forms of GBV.

Specific services that are required include establishing places of refuge, specially training health care workers, and providing rehabilitation and counselling services.[202] DEVAW is particularly progressive in the services that it recommends for SGBV. For example, DEVAW recognises the need for child care and maintenance to be provided to SGBV.[203] While such services are expensive, they should at least be considered in light of the requirement to "progressively realise" the right to have access to health care services for women in the Constitution, in addition to the constitutional commitment to gender equality.[204] The CEDAW Committee has further recommended that South Africa make the necessary budgetary allocations in order to implement such provisions.[205]

In relation to existing legislation on GBV, the CEDAW Committee has advised South Africa to take steps to facilitate the effective implementation of the provisions

[199] The 2006 Report of the Special rapporteur on Violence against Women, para 38.
[200] Concluding observations, para 36(a).
[201] Concluding observations, para 40.
[202] General Recommendation 19,para 24(k).
[203] DEVAW, para 4(g).
[204] Founding provisions of the Constitution.
[205] Concluding observations, para 25(d).

in the Domestic Violence Act 116 of 1998 and the Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007.[206] Given the integral importance of the health care system in identifying SGBV, this necessarily requires placing duties on the Department of Health while simultaneously training health care providers to identify and address all forms of GBV.

Most importantly, the developments under CEDAW have illustrated that the right to be free from GBV and the right to health do not only entail negative obligations on the part of the state. In accordance with the due diligence rule, these rights also require that States take reasonable steps to protect women from GBV and to provide reparation in the form of appropriate and responsive health care services. The CEDAW committee has also made it clear that these obligations on the part of the State extend to inhibiting private actors from infringing upon the human rights of women, including health care workers.[207] The regional system, which may also offer some guidance of international standards to which South Africa should aspire, shall now be considered.

4 5 The Regional Human Rights Systems

4 5 1 The African System

The African Charter on Human and Peoples' Rights (hereafter the "African Charter"),[208] which is also known as the Banjul Charter, was adopted in 1981 and entered into force in 1986. South Africa ratifued the African Charter on 9 July 1996. Article 16 of the African Charter provides that every individual has the right to enjoy the best attainable state of physical and mental health. In 1996 the African Commission on Human and People's Rights (hereafter the "African Commission") made a landmark decision in relation to environmental rights, housing rights and health rights in the case of *Social and Economic Rights Action Center & the Center for Economic and Social Rights v Nigeria.* [209] In this case, the then military government of Nigeria had failed to protect the rights of the Ogoni communities by

[206] United Nations Committee on the Elimination of Discrimination against Women *Goekce (deceased) v Austria* (Communication No. 6/2005) Reference No: CEDAW/C/39/D/5/2005, para 12.3. (a); Concluding observations, para 25.
[207] Bayefsky (2000) *Proceedings of the Annual Meeting (American Society of International Law)* 197.
[208] African Charter on Human and Peoples' Rights (1981) OAU Doc CAB/LEG/67/rev.5.
[209] African Commission on Human and People's Rights *Social and Economic Rights Action Center & the Center for Economic and Social Rights v. Nigeria* Communication No. 155/96.

facilitating the environmental pollution perpetrated by oil companies. The Commission ruled that the Nigerian government had violated the right to health (article 16) and the right to a general satisfactory environment favourable to development (article 24). It held further that the State's failure to adequately regulate the activities of the oil companies, or to allow the Ogoni people to have any participatory say in the manner in which their resources were handled, had violated the right of the Ogoni people to freely dispose of their wealth and natural resources (article 21). The case was significant in that the Commission discussed both the positive and negative duties created by the relevant rights within the African Charter. The Commission also affirmed that States have a positive duty to protect their citizens from damaging acts that may be perpetrated by private parties.

In 2001 the African Commission decided the case of *Purohit and Moore v The Gambia.*[210] In this case the applicants alleged that the legislative regime in The Gambia for mental health patients (the Lunatics Detention Act) was outdated and effectively violated the right to enjoy the best attainable state of physical and mental health (article 16) and the right of the disabled to special measures of protection in keeping with their physical and moral needs (article 18(4)). The Lunatics Detention Act was specifically criticised for failing to contain a definition of who a lunatic is, while failing to establish safeguards during the diagnosis, certification and detention of a patient. Ultimately, the African Commission found The Gambia guilty of failing to satisfy the requirements of Articles 16 and 18(4) of the African Charter. The African Commission went on to state that the enjoyment of the right to health is crucial for the enjoyment of other fundamental rights and freedoms and that article 16 requires States to take concrete positive steps to ensure adequate material and therapeutic conditions for mental health patients.[211] This case is important for South Africa, given our general neglect of mental health care.[212]

In relation to the protection of women from violence, the African Charter has been criticised for not addressing women's rights as extensively as CEDAW.[213] The African Charter does however, specifically require States to:

---

[210] African Commission on Human and People's Rights *Purohit and Moore v The Gambia* Communication No.241/2001.
[211] African Commission on Human and People's rights *Purohit and Moore v The Gambia* Communication No.241/2001, para 83.
[212] I Petersen "Comprehensive Integrated Primary Mental Health Care for South Africa: Pipedream or Possibility?" (2000) 51 *Social Science & Medicine* 321 330.
[213] C E Welch "Human Rights and African Women: A Comparison of Protection under Two Major Treaties" (1993) 15 *Human Rights Quarterly* 549 554.

> "Ensure the elimination of every discrimination against women and to also ensure the protection of the rights of the woman and the child as stipulated in international declarations and conventions."[214]

While the African Charter provides measures on protecting women from GBV, the formulation of these rights have been criticised, in addition to the ineffective implementation of such rights.[215] For example, while women are provided with the right to enjoy a safe home environment, this is a sub right, as the family unit is protected as the foundational basis of society.[216] The family is also recognised as the custodian of morals and traditional values recognised by the community.[217] As pointed out by Jennifer Nedelsky, this reveals a tension between culture and equality, making it difficult to achieve transformation within a system whose foundation is reverence for tradition.[218]

The African Commission has however adopted progressive principles and guidelines on the implementation of the economic, social and cultural rights contained in the African Charter. These guidelines specifically refer to women's health care needs and the need to prevent violence against women. For example, as a minimum core obligation, States are required to include a gender perspective in national health plans and policies in order to promote better health for both men and women.[219] States are also required to take measures to prevent violence against women and to mitigate its impact on the physical and mental health of SGBV. The guidelines further require that States train health care personnel in order to ensure humane and sympathetic treatment and counselling and rehabilitation for SGBV. It also requires the provision of alternative and safe housing programmes for women fleeing situations of domestic violence.[220]

There has also been great progress within the broader African region, with various other measures introduced in an attempt to address violence against women. One such example is the 1997 Southern African Development Community (SADC)

---

[214] Article 18(3) of the African Charter on Human and Peoples' Rights.
[215] Meyersfeld *Domestic Violence* 89.
[216] Article 18(1) of the African Charter on Human and Peoples' Rights.
[217] Article 18(2) of the African Charter on Human and Peoples' Rights.
[218] J Nedelsky "Violence against Women: Challenges to the Liberal State and Relational Feminism" in I Shapiro & R Hardin (eds) *Political Order* (1998) 454 484-485.
[219] The African Commission on Human and People's Rights "Principles and Guidelines on the Implementation of Economic, Social and Cultural Rights in the African Charter on Human and Peoples' Rights", para 67 xxvi.
[220] The African Commission on Human and People's Rights "Principles and Guidelines on the Implementation of Economic, Social and Cultural Rights in the African Charter on Human and Peoples' Rights", para 67 xxxv.

Protocol on Gender and Development which specifically addresses GBV in Part 6 of the SADC Protocol. In relation to services for SGBV, article 23(2) of the SADC Protocol specifically requires that States provide accessible, effective and responsive health care services.

In July of 2003 the African Union adopted the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (hereafter the "Women's Protocol")[221] which came into force in 2005. The Women's Protocol is to serve as a supplement to the Banjul Charter and reinforces the prominence of women's rights in other international and regional instruments. On 17 December 2004, South Africa ratified the Women's Protocol.

Article 4 of the Women's Protocol specifically states that women are entitled to respect for their lives and the integrity of their person. Article 4 goes on to state that State Parties shall protect girls and women against all forms of violence, including the trafficking of girls and women.[222] Article 5 sets out specific steps that States Parties shall take to protect women, including identifying the causes of violence and taking appropriate measures to prevent such violence. Article 5 also requires the punishment of perpetrators, provisions to ensure that perpetrators pay adequate compensation and mechanisms to ensure rehabilitation and reparation for victims of such violence.

The Women's Protocol provides for the protection of sexual and reproductive health in article 14.[223] The Women's Protocol therefore specifically recognises women's rights to protect themselves from HIV,[224] in addition to women's rights to an

---

[221] Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (2000) CAB/LEG/66.6.

[222] Article 4(c) of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (2000) CAB/LEG/66.6.

[223] Article 14(1) State Parties shall ensure that the right to health of women are respected and promoted. These rights include:
a) the right to control their fertility;
b) the right to decide whether to have children;
c) the right to space their children;
d) the right to choose any method of contraception;
e) the right to protect themselves against sexually transmitted diseases, including HIV/AIDs;
f) the right to be informed on one's health status and on the health status of one's partner.
2. State Parties shall take appropriate measures to:
a) provide adequate, affordable and accessible health services to women especially those in rural areas;
b) establish pre-and post-natal health and nutritional services for women during pregnancy and while they are breast-feeding;
c) protect the reproductive rights of women particularly by authorising medical abortion in cases of rape and incest.

[224] E Durojaye "Advancing Gender Equity in Access to HIV Treatment Through the Protocol on the Rights of Women in Africa" (2006) 6 *African Human Rights Law Journal* 188 195.

abortion when pregnancy results from rape or incest. It thereby focuses on the interests of women, as individual rights-bearers, in contrast to simply reducing women to their reproductive element. It is also the first instrument in international law to call for the legal prohibition of female genital mutilation.[225] The Women's Protocol is thus an important source of international law and provides evidence of the existence of a right and a corresponding State duty to protect women from all forms of violence.[226]

In July of 2004, even more support for the human rights of women was articulated at the Solemn Declaration on Gender Equality, which was held at the African Union Summit Meeting. In this Declaration, the Heads of Member States, which includes South Africa, agreed to initiate, launch and engage in sustained public campaigns against GBV as well as the problem of trafficking in women and girls. They also committed to reinforce legal mechanisms that will protect women at the national level while ending impunity for crimes committed against women. In 2005, the African Union also adopted the Implementation Framework of the Solemn Declaration on Gender Equality in Africa. The Framework seeks to eliminate GBV by 2015. This therefore reveals that there is increasing support within the African region in relation to transforming attitudes that encourage impunity for GBV and in developing an international agenda to eliminate GBV.

4 5 2 The European system

While the European regional system is not binding on South Africa, in accordance with section 39(1)(b) of the Constitution, and the decision of *S v Makwanyane and Another*,[227] the European system may provide valuable guidance in interpreting section 27 of the Constitution.

The European Convention for the Protection of Human Rights and Fundamental Freedoms (hereafter the "European Convention") was adopted by the Council of Europe in 1950. The European Convention explicitly prohibits sex discrimination,[228]

---

[225] Article 16 of the Women's Protocol specifically calls for the elimination of harmful practices.
[226] Meyersfeld *Domestic Violence* 90.
[227] *S v Makwanyane and Another* 1995 2 SACR 1; 1995 6 BCLR 665; [1995] ZACC 3.
[228] European Convention for the Protection of Human Rights and Fundamental Freedoms (the European Convention) (1950) 213 UNTS 222 article 14:

> "The enjoyment of the rights and freedoms set forth in this Convention shall be secured without discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status."

while protecting civil and political rights. Under the European Social Charter of 1961, economic, social and cultural rights are explicitly protected, with articles 11 and 13 protecting the right to health.[229] Under the revised Social Charter of 1996, the right to health is protected in article 11 and article 13, while the right to non-discrimination is protected under article E.[230] The 1961 Charter is applicable to those States that have not yet ratified the Revised Social Charter.

The European Committee on Social Rights supervises the implementation of the Social Charter and the Revised Social Charter. In 2008 the European Committee delivered a landmark judgment in the case of *European Roma Rights Centre v Bulgaria.*[231] This case is particularly important as the Committee held Bulgaria liable for failing to establish a system of health care that addresses the health care needs of a particularly vulnerable group within Bulgaria (the Romani). The Committee referred to the refusal of health care authorities to send emergency ambulances to Romani districts, the segregation of Romani women in maternity wards and the use of racially offensive language by health care providers. These factors, together with the fact that the Romani live in unhealthy environments and are disproportionately affected by a lack of access to the underlying determinants of health, led the Committee to find that Bulgaria had failed to meet its positive obligations to ensure that the Romani enjoy adequate access to health care. In particular the Committee found that Bulgaria had failed to take reasonable steps to address the specific problems faced by Roma communities. This cumulatively led to the Committee's

---

[229] Article 11
"The right to protection of health: With a view to ensuring the effective exercise of the right to protection of health, the Contracting Parties undertake, either directly or in co-operation with public or private organisations, to take appropriate measures designed *inter alia:*
1. to remove as far as possible the causes of ill-health;
2. to provide advisory and educational facilities for the promotion of health and the encouragement of individual responsibility in matters of health;
3. to prevent as far as possible epidemic, endemic and other diseases."

[230] Article 11 – The right to protection of health
Part I: "Everyone has the right to benefit from any measures enabling him to enjoy the highest possible standard of health attainable." Part II: "With a view to ensuring the effective exercise of the right to protection of health, the Parties undertake, either directly or in cooperation with public or private organisations, to take appropriate measures designed inter alia:
1. to remove as far as possible the causes of ill-health;
2. to provide advisory and educational facilities for the promotion of health and the encouragement of individual responsibility in matters of health;
3. to prevent as far as possible epidemic, endemic and other diseases, as well as accidents."
Article E – Non-discrimination
"The enjoyment of the rights set forth in this Charter shall be secured without discrimination on any ground such as race, colour, sex, language, religion, political or other opinion, national extraction or social origin, health, association with a national minority, birth or other status.

[231] European Committee on Social Rights *European Roma Rights Centre v Bulgaria* Collective Complaint 46/2007.

overall conclusion that Roma in Bulgaria do not benefit from appropriate responses to their general and specific health care needs. This case is of particular importance in South Africa, given the imbalance between the public and private health care systems in South Africa, which disproportionately affects vulnerable groups.

In relation to violence against women, the parliamentary assembly of the Council of Europe has recognised domestic violence as the major cause of death and disability of women between the ages of 16 and 44, ahead of cancer, road accidents and even war. The parliamentary assembly thus states that domestic violence should be treated as a "political and public problem, and a violation of human rights."[232]

In 2002 the Committee of Ministers of the Council of Europe released a recommendation on the protection of women from violence.[233] The recommendation sets out specific steps that States should take to protect women, including the taking of measures to ensure that no victims of violence suffer secondary victimisation or any gender-insensitivity by police, judicial, health and social personnel.[234] The recommendation is also progressive in that it provides that victims of violence may receive appropriate compensation for any pecuniary, physical, psychological, moral and social damage suffered, corresponding to the degree of gravity, including legal costs incurred.[235]

In 2011, The Council of Europe went on to adopt the Convention on Preventing and Combating Violence against Women and Domestic Violence.[236] Article 20(2) of the Convention specifically requires that States Parties to the Convention take necessary legislative or other measures to ensure that victims have access to health care and social services and that existing services are adequately resourced. It also requires that professionals are trained to assist victims and refer them to the appropriate services.

The European Court of Human Rights has also decided some of the more progressive decisions in terms of State responsibility for violence against women. For example, in 2008 the European Court of Human Rights heard the ground-breaking case of *Opuz v Turkey.*[237] In this case the applicant, Mrs Nahide Opuz, claimed that

[232] Parliamentary Assembly of the Council of Europe, "Recommendation 1582 (2002) Domestic Violence against Women' (27 September 2002) section 2.
[233] Council of Europe Committee of Ministers "The Protection of Women against Violence" Recommendation (2002) 5 <https://wcd.coe.int/ViewDoc.jsp?id=280915> (accessed 12-05-2012).
[234] Paragraph 33 of the Recommendation on the Protection of Women against Violence.
[235] Paragraph 36 of the Recommendation on the Protection of Women against Violence.
[236] Council of Europe "Convention on Preventing and Combating Violence against Women and Domestic Violence" (2011) CETS No 210.
[237] European Court of Human Rights *Opuz v Turkey*, (2009) 2 ECHR Application number 33401/02.

Turkey had infringed the European Convention on Human Rights by failing to take sufficient action against her abusive husband. Over a period of twelve years, the applicant's husband had subjected her and her mother to severe forms of violence, including brutal beatings, a knife attack and attempting to run the applicant and her mother over with his car. In 1996, after a particularly brutal physical beating, the applicant was examined by a doctor, with the medical report concluding that the applicant's injuries were sufficient to endanger her life.[238] This effectively reveals the devastating health consequences of GBV, in addition to the integral role of health care providers in collecting evidence and recognising GBV. After twelve years of violence and threats, in 2002, the applicant's husband shot and murdered her mother. It is important to note that the applicant and her mother had sought the protection of the State on at least five occasions prior to this.

This was ultimately a ground-breaking case as the Court decided that in this particular case, the physical and psychological violence suffered by the applicant was sufficiently serious enough to amount to ill- treatment within the definition of torture under article 3 of the European Convention.[239] The Court also affirmed that Turkey had violated article 2 (the right to life), article 3 (the right to be free from torture), and article 14 (the right to the equal enjoyment of the rights in the Convention), by failing to address the problem.

The European Court of Human Rights further confirmed that States have enforceable and justiciable obligations to take reasonable steps to protect individuals from domestic violence.[240] The Court specifically pointed out that the passivity of the criminal law system in addressing domestic violence had created an environment conducive to violence being perpetrated against women.[241] The Court thus criticised Turkey's legislative framework which required that the authorities discontinue criminal proceedings when a complaint was withdrawn by a complainant. The Court held that the authorities should have been able to continue the proceedings, given the gravity of the violence. This goes a long way in recognising the complex and torturous nature of abusive intimate relationships and in developing State responsibilities in terms of positive interventions to assist abused women.

---

[238] European Court of Human Rights *Opuz v Turkey*, (2009) 2 ECHR Application number 33401/02 para 13.
[239] European Court of Human Rights *Opuz v Turkey*, (2009) 2 ECHR Application number 33401/02, para 161.
[240] European Court of Human Rights *Opuz v Turkey*, (2009) 2 ECHR Application number 33401/02 para 136.
[241] European Convention for the Protection of Human Rights and Fundamental Freedoms 213 UNTS 222.

4 5 3 The Inter-American System

The Organisation of American States (hereafter the "OAS") recognises socio-economic rights in a range of instruments. For example, the American Convention on Human Rights (hereafter the "American Convention"),[242] requires States Parties to adopt measures to progressively achieve, the realisation of the rights implicit in the economic, social, educational, scientific, and cultural standards set forth in the Charter of the Organisation of American States as amended by the Protocol of Buenos Aires.[243]

Subsequently, in 1989, the OAS adopted the additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights (hereafter the "American protocol").[244] Article 10 of the American protocol specifically states that everyone shall have the right to the highest level of physical, mental and social well-being. The American protocol sets out that States must take steps to provide essential health care to all individuals. States are also required to extend benefits of health services to all individuals subject to the State's jurisdiction, provide universal immunisation and prevent and treat endemic, occupational and other diseases. States are further required to educate the population on the prevention and treatment of health problems, and to satisfy the health needs of the highest risk groups and of those whose poverty makes them the most vulnerable.

In 1994 the OAS adopted the Inter-American Convention on the Prevention, Punishment and Eradication of Violence against Women (*Convention of Belem do Para*).[245] The Convention of Belem do Para is directed solely at eliminating violence against women. The Convention has been recognised for its identification of violence against women as an offence against human dignity and a manifestation of the historically unequal power relations between women and men.[246] It has also been praised for its extensive definition of violence,[247] which includes a description of

---

[242] American Convention on Human Rights (1969) O.A.S.Treaty Series No. 36, 1144 UNTS 123 (hereafter "American Convention").
[243] Article 26 of the American Convention.
[244] Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights OAS Treaty Series No. 69.
[245] Inter-American Convention on the Prevention, Punishment and Eradication of Violence against Women (1994).
[246] Preamble to the Inter-American Convention on the Prevention, Punishment and Eradication of Violence against Women (1994).
[247] See: Article 2 of the Convention:
"Violence against women shall be understood to include physical, sexual and psychological violence: a) that occurs within the family or domestic unit or within any other interpersonal relationship, whether or not the perpetrator shares or has shared the same residence with the

violence against women in health care facilities. This is even more detailed than the description of violence under DEVAW.[248]

It is also noteworthy for having provided a complaint mechanism long before CEDAW did. The Convention goes on to provide for the equal protection of civil, political, social and economic rights (article 5) and the right of women to be free from violence including all forms of discrimination (such as stereotypes and discriminatory social and cultural practices) (article 6). This Convention thus contains key terms that effectively erode the public/private law distinction in addition to the civil/political and socio-economic rights distinction.

The Inter-American Commission on Human Rights has also delivered progressive decisions that have expanded upon States' obligations to protect women from violence. For example, in 2001, the Commission decided the case of *Fernandes v Brazil*[249] under articles 44 and 46 of the American Convention[250] and article 12 of the *Convention of Belem do Para*.[251] In this case a Brazilian woman named Maria was shot by her husband while sleeping. This resulted in her becoming paralysed from the waist down. Despite the severity of the violence, her husband remained free from imprisonment for nearly two decades, eventually only spending two years in prison. Ultimately the Inter-American Commission on Human Rights emphasised that under the due diligence rule it is not enough for States to have progressive laws, but that such laws need to be effectively implemented. This case highlighted the severe health consequences of violence against women, in addition to the manner in which failure to prosecute such violence effectively indicates condonation of such violence.

---

woman, including, among others, rape, battery and sexual abuse, b) that occurs in the community and is perpetrated by any person, including, among others, rape, sexual abuse, torture, trafficking in persons, forced prostitution, kidnapping and sexual harassment in the workplace, as well as in educational institutions, health facilities or any other place, and c) that is perpetrated or condoned by the state or its agents regardless of where it occurs."

[248] Meyersfeld *Domestic Violence* 80.

[249] Inter-American Commission on Human Rights *Maria Da Penha Maia Fernandes v Brazil* Report No 54/01 Case 12.051 OEA/Ser.L/V/II.111 Doc. 20 rev. at 704 (2000).

[250] Article 44 of the American Convention allows any person or group of persons to lodge petitions with the Commission containing complaints of violations of the American Convention by a State party. Article 46 of the American Convention provides the particular requirements that such a petition must fulfill.

[251] Article 12 of the Inter-American Convention on the Prevention, Punishment and Eradication of Violence against Women (1994) allows any person or group of persons to lodge petitions with the Commission on Human Rights containing complaints of violations of article 7 of this Convention by a State party. Article 7 states that States Parties must condemn all forms of violence against women and agree to pursue, by all appropriate means and without delay, policies to prevent, punish and eradicate such violence.

In 2007, the Inter-American Commission on Human Rights delivered another landmark decision in *Jessica Lenahan (Gonzales) v United States.*[252] In this case it was alleged that the United States had violated various articles of the American Declaration of the Rights and Duties of Man[253] by failing to exercise due diligence to protect Jessica and her daughters from acts of domestic violence. In this particular case, Jessica's three children had been killed by her estranged husband after local police had failed to enforce a restraining order against him. This was the first case in which the Inter-American Commission on Human Rights had to determine the potential positive duties of an American State in protecting individuals from private acts of violence under the American Declaration on the Rights and Duties of Man.[254] While the United States government argued that the Declaration does not impose any positive obligations due to the lack of any explicit obligations within the Declaration, the Inter-American Commission on Human Rights disagreed. Ultimately, the Commission held that the United States was liable under the well-established international standard under the "due diligence" rule, to prevent, investigate, and punish human rights violations and to protect and compensate complainants. The Commission thus found the United States guilty of violating various articles of the American Declaration.

While the Commission's decisions are not binding on South Africa, this decision does carry significant moral and political weight and assists in contributing to international standards to protect women from violence.[255] It also reveals that inadequate national laws do not constitute a satisfactory excuse for failing to address violence against women.

4 6 Conclusion

The right to health is protected at both the international and the regional level and requires that States take positive steps to respect, protect and fulfil this right. Furthermore, international and regional human rights instruments and treaty-supervising Committees, consistently affirm that GBV triggers positive State

[252] Inter-American Commission on Human Rights *Jessica Lenahan (Gonzales) v United States* Report No. 80/11 Case 12.626.
[253] American Declaration of the Rights and Duties of Man OAS doc. OEA/Ser.L/V/II.65,Doc 6.
[254] As a result of the United States not ratifying any Inter-American human rights treaties, human rights complaints against the United States are brought before the Commission under the American Declaration and the Organisation of American States Charter.
[255] C Bettinger-Lopez "*Jessic Gonzales v United States:* An Emerging Model for Domestic Violence & Human Rights Advocacy in the United States (2008) 21 *Harvard Human Rights* 183 185.

obligations. This is in terms of the due diligence rule under international law, which requires that States take reasonable steps to prevent GBV and to offer reparation to SGBV. States are thus required to draft adequate health care legislation and policies that specifically provide quality[256] health care interventions to identify, treat and protect SGBV. States also need to take positive steps to implement such laws, while allocating sufficient resources for the implementation of such health care interventions.[257]

International law also highlights the need to cater for the specific needs of different groups, including women, children and those who cannot afford to pay for such services.[258] General Comment 14 specifically emphasises the need to develop a national strategy to promote women's particular health care needs, with a special focus on maternal mortality and measures to combat domestic violence.[259] The CEDAW Committee has further required that national legislation and policy be drafted to address all forms of discrimination against women, thus requiring a more holistic conception of GBV.[260]

The CEDAW Committee and UNESCR have also called for the removal of obstacles to women's equal access to health care services. States are thus required to improve transport services while adequately training health care providers so as to facilitate access to health care services for abused women.[261] States also need to develop and broaden health care services for specific forms of GBV, such as domestic violence. Under international law standards, such services should be broadened to include trauma services, counselling and rehabilitation for SGBV.[262] The requirement under DEVAW to provide child care services and maintenance[263] further illustrates how services for SGBV could be broadened to alleviate the socio-economic burdens experienced by many women.

Under both UNESCR and the CEDAW Committee States are further obliged to protect the rights to be free from non-consensual medical treatment, such as forced sterilisations.[264] Decisions under treaty supervisory bodies, such as the CEDAW

[256] General Comment No 14, para 12(d).
[257] Meyersfeld *Domestic Violence* 151.
[258] UDHR, article 16; General Comment 20, para 4.
[259] General Comment No 14, para 21.
[260] Concluding observations, paras 20 and 40.
[261] General Recommendation No 19, paras 106(q), 24(b); General Recommendation No 24, para 15(b) and the Recommendation on the Protection of Women against Violence, para 33.
[262] General Recommendation No 24, paras 16 and 24(m).
[263] DEVAW, article 4(g).
[264] General Recommendation No 19, para 24(m).

Committee have also pointed out that States may be held accountable for the violations of private actors, including health care workers and police personnel.[265]

The human rights standards enunciated in international law thus provide normative markers for evaluating South Africa's health care system. In considering international standards relating to the accessibility and the availability of health care services, South Africa needs to take steps to improve the quality of public health care services. Simultaneously, health care providers need to be adequately trained to recognise and address GBV, while health care services for SGBV need to be expanded to incorporate adequate psychological health care services.[266] There is therefore, room to expand current health care policies and programmes under South African law to be more in line with international standards and recommendations.[267] The following chapter will thus consider how international law can be utilised to identify a package of health care interventions to be provided to SGBV.

[265] Bayefsky (2000) *Proceedings of the Annual Meeting (American Society of International Law)* 197.
[266] See: Chapter three, pages 72 and 80.
[267] Meyersfeld *Domestic Violence* xxxiv.

5 An interrelated approach to developing health care interventions for survivors of GBV

5 1 Introduction

Gender-based violence (hereafter "GBV") kills and disables as many women between the ages of 15 and 44 as cancer.[1] Research has also revealed that its toll on women's health surpasses that of traffic accidents and malaria combined.[2] In spite of this reality, GBV continues to be neglected, under-documented and under-reported by the South African health care system.[3]

While the devastating health consequences of GBV cannot be prevented completely, many of these consequences could be ameliorated by a comprehensive and multi-dimensional health care response. For example, adequate health care services have the potential to assist in preventing future acts of violence.[4] Quality health care interventions can also reduce the potential for disability and can help women to cope with the impact of violence in their lives.[5]

In order to advance the constitutional rights of abused women, the health care response to GBV therefore needs to be infused with substantive equality. This is necessary as an interrelated approach reveals the multidimensional nature of disadvantage,[6] while recognising that sometimes positive measures are needed in order to advance certain groups or individuals that have experienced past discrimination.[7] A substantive commitment to equality further recognises the need for integrated and co-ordinated health care interventions in order to ensure that all women who have experienced GBV are protected and recognised. [8] The

---

[1] United Nations Population Fund "Gender-Based Violence: A Price Too High" in *State of the World Population 2005: The Promise of Equality: Gender Equity, Reproductive Health and the Millennium Development Goals* (2005) 65 65 <http://www.unfpa.org/swp/2005/index.htm> (accessed 24-02-2011).
[2] United Nations Population Fund *State of the World Population 2005: The Promise of Equality* (2005) 65.
[3] K Joyner *Health Care for Intimate Partner Violence: Current Standards of Care and Development of Protocol Management* DPhil thesis Stellenbosch University (2009) 1 103.
[4] J Mercy, A Butchart, M Rosenberg, L Dahlberg & A Harvey "Preventing Violence in Developing Countries: A Framework for Action" (2008) 15 *International Journal of Injury Control and Safety Promotion* 197 199.
[5] Mercy et al (2008) *International Journal of Injury Control and Safety Promotion* 199.
[6] C Albertyn "Substantive Equality and Transformation in South Africa" (2007) 23 *SAJHR* 253 253.
[7] Section 9(2) of the Constitution of the Republic of South Africa, 1996 (hereafter "the Constitution") specifically states that :

> "To promote the achievement of equality, legislative and other measures designed to protect or advance persons or categories of persons, disadvantaged by unfair discrimination may be taken".

[8] *Government of the Republic of South Africa v Grootboom and Others* 2001 1 SA 46 (CC); 2000 11 BCLR 1169 (CC) para 78.

constitutional commitment to "heal the divisions of the past" and to establish a society based on "social justice and fundamental human rights" [9] clearly illustrates a commitment to addressing systemic inequality. The inclusion of the right to equality[10] and the socio-economic rights[11] further evinces this commitment.

This chapter therefore applies the normative framework of an interrelated approach between the right to equality and the right to have access to health care services, which was developed in chapter two, to outline a package of health care interventions to be provided to survivors of GBV (hereafter "SGBV"). Relevant principles within international law (as identified in chapter four) will also be used to identify promising health care interventions. This is in order to fulfil the right to have access to health care services under our transformative Constitution, for SGBV. While all forms of GBV need to prioritised by the Department of Health, this chapter will focus on the particular health care interventions that are required in relation to domestic violence and rape.

5 2 A gender-sensitive interpretation of the right to have access to health care services

Substantive gender equality concerns understanding gender inequality within its social and historical context.[12] It entails a concern with the impact of inadequate health care services on the lived realities of women, while recognising the biological and gender-based differences between men and women.[13] It further entails paying attention to the purpose of the right to have access to health care services and its underlying values in a manner that evinces a concern with remedying systemic gender subordination.[14] Together, the right to equality and the right to have access to health care services are able to recognise the numerous intersecting factors that deepen vulnerability to violence and ill-health. Through positive legislative and other measures to advance women, the State is also able to dislodge the entrenched forms of disadvantage that many women experience. Infusing the right to have access to health care services with the right to substantive equality therefore has the transformative potential to alleviate the burden of disease that many women

[9] Preamble to the Constitution.
[10] Section 9 of the Constitution.
[11] Section 26, section 27 and section 28 of the Constitution.
[12] Albertyn (2007) *SAJHR* 259.
[13] Albertyn (2007) *SAJHR* 259.
[14] Albertyn (2007) S*AJHR* 258.

experience.[15] As pointed out in chapter two, an interrelated interpretation between the right to substantive equality and the right to have access to health care services is thus more consonant with the transformative aspirations of our Constitution.

Chapter two focused on the implications of an interrelated approach for encouraging a jurisprudence which is sensitive and responsive to the gendered realities and needs of women. This chapter is primarily focused on utilising an engendered approach to section 27(1)(a) of the Constitution to develop health care interventions for SGBV.

In relation to the contextual analysis of substantive equality, Sandra Fredman points out that in order to foster substantive gender equality, health care rights cannot simply be extended to women on equal terms with men. Rather, health care rights and institutions need to be reshaped to reflect the social context of gender inequality.[16] Health care policies therefore need to be informed by the intersecting forms of disadvantage that many poor women experience. For example, the epidemic levels of GBV within South Africa effectively intersect with poor women's socio-economic burdens[17] to compound women's ill health. Thus, women are not only biologically more susceptible to HIV infection; [18] they are also more vulnerable to sexual violence, while being the primary caregivers to people living with HIV/AIDS.[19] This has resulted in HIV/AIDS becoming a gendered epidemic. [20]

Sensitivity to the historical and social context of gender inequality is thus necessary as women experience violence, poverty and ill health differently from men.[21] For example, women are more likely to be attacked by someone they know, implicating potential emotional, social and economic dependency on their abuser. Simultaneously, the economic and social realms that women are expected to tread, overextends the range of roles and responsibilities that poor women take on.[22] For example, in rural areas women are expected to care for others, to cook, to clean and

---

[15] Department of Health "Annual Performance Plan" 2011/2012- 2012/2013 <http://www.doh.gov.za/docs/stratdocs/2011/annual_plan11.pdf> (accessed 13-01-2012).
[16] S Fredman "Engendering Socio-Economic Rights" (2009) 25 *SAJHR* 410 411.
[17] S Chant "Re-thinking the Feminisation of Poverty in regard to Aggregate Gender Indices (2006) 7 *Journal of Human Development* 201 206.
[18] S Chisala "Rape and HIV/AIDS: Who's Protecting Whom?" in L Artz & D Smythe (eds) *Should We Consent?: Rape Law Reform in South Africa* (2008) 52, on page 55, Chisala observes that this biological vulnerability is a result of the fact that semen carries a high viral load, and because of the physiological nature of the vagina which has a large mucosal area.
[19] *Mazibuko v City of Johannesburg (Centre on Housing Rights and Evictions as Amicus Curiae)* [2008] 4 All SA 471 (W) para 172.
[20] Chisala "Rape and HIV/AIDS" in *Should We Consent?* 55.
[21] Chant (2006) *Journal of Human Development* 208.
[22] Chant (2006) *Journal of Human Development* 208.

to fetch firewood and water.[23] Using wood and other plant materials to cook food is unhealthy and has resulted in many women developing respiratory diseases and lung cancer.[24] The burden of caring work that many poor women take on also makes it difficult for such women to enter the labour market and to earn a sufficient income to pay for quality services. Caring work, while satisfying, is particularly time-intensive making it difficult for women to access health care services or to fulfil their other personal needs. The feminisation of such socio-economic burdens further results in women being forced to enter into sex work or to stay with an abusive partner in order to survive, which has severe health implications. This reveals that both gender and biology have implications for one's health. It further reveals that men and women experience socio-economic disadvantage differently and that many poor women's choices are shaped by both visible and invisible forms of gendered oppression.[25]

In relation to the impact of inadequate health care services on women, health care services should be carefully analysed to determine their impact on the lived reality of women.[26] For example, the failure to recognise GBV as a public health crisis that warrants quality health care interventions is to effectively ignore the suffering of a large proportion of women. The inadequate recognition of GBV also effectively entrenches the normative nature of such violence while failing to address the secondary victimisation of abused women.[27] Even the structural challenges that are facing South Africa's public health care system (many of which were discussed in detail in chapter three),[28] have a disproportionate impact upon women. For example, the lack of sufficient health care facilities in rural areas and the lack of emergency transport disproportionately affect women and children.[29] Epidemic levels of GBV also serve as obstacles to women utilising transport facilities in general. The impact of inadequate social services, including health care services for SGBV should

[23] J Dugard & N Mohlakoana "More Work for Women: A Rights-Based Analysis of Women's Access to Basic Services in South Africa" in B Goldblatt & K McLean (eds) *Women's Social and Economic Rights* (2011)157.
[24] Dugard & Mohlakoana "More Work for Women" in *Women's Social and Economic Rights* 158.
[25] Albertyn (2007) *SAJHR* 265.
[26] D M Chirwa & S Khoza "Towards Enhanced Citizenship and Poverty Eradication: A Critique of *Grootboom* from a Gender Perspective" in A Gouws (ed) *(Un)thinking Citizenship: Feminist Debates in Contemporary South Africa* (2005) 137 210.
[27] S Bornman, D Budlender, L Vetten, C van der Westhuizen, J Watson & J Williams (Women's Legal Centre) "The State of the Nation, Government Priorities & Women in South Africa: Decent Work, Education, Crime, Health, Rural Development & Land Reform" (2012) 3.
[28] See chapter three, pages 50-51.
[29] Tshwaranang Legal Advocacy Centre "Submission to the Portfolio Committee & Select Committee on Women, Youth, Children and People with Disabilities: Implementation of the Domestic Violence Act 116 of 1998" (2009) 6 <http://www.tlac.org.za/wp-content/uploads/2012/01/Submission-health-sector-response-to-domestic-violence.pdf> (accessed 12-04-2011).

similarly be analysed in terms of the constitutional goals and values. For example, failing to address the gendered reality of women's lives fails to facilitate the realisation of the constitutional goals of a non-sexist society where all are able to reach their full human potential.[30] In order for health care institutions to be effectively engendered, the State will therefore need to address these obstacles.

The failure to adequately address the reality of gender inequality in health care policies on HIV/AIDS prevention has correspondingly resulted in non-effective health care interventions. This was highlighted in research which revealed that the use of condoms is an intervention whose efficacy lies almost exclusively in men's control.[31] This is due to men's infamous aversion to using condoms, with even the suggestion of condom usage often resulting in women being physically abused or accused of infidelity.[32]

The manner in which the Department of Health has approached testing for HIV/AIDS has also inadvertently disadvantaged women. For example, as women are primarily responsible for child care, they predominantly accompany children to health care services, or are forced to obtain health care services when they are pregnant. They are then subjected to extreme pressure to test for, and to treat HIV/AIDS, in order to protect the best interests of their child.[33] While the interests of children are of paramount importance,[34] sacrificing the rights of women will ultimately cause more harm than good. The act of increasing women's socio-economic responsibilities without increasing their benefits or their rewards is further problematic and may create a new and deeper form of female exploitation.[35] Such an approach further entrenches the culture of social blame that is heaped on poor women. For example, in the Eastern Cape, the HIV/AIDS epidemic has become known as a "women's disease" or a "prostitutes disease."[36] This reveals that certain health care policies, such as policies encouraging condom usage and testing for HIV, are not gender neutral and apolitical interventions. It also reveals that the manner in which these policies have been implemented have had a disproportionate effect on women.

---

[30] Preamble of the Constitution.
[31] D Nath (One in Nine Campaign) "We were Never meant to Survive: Violence in the Lives of HIV Positive Women in South Africa" (2012) 25 <http://www.oneinnine.org.za/58.page> (accessed 04-06-2012).
[32] Nath "We were Never Meant to Survive" (2012) 26.
[33] Nath "We were Never Meant to Survive" (2012) 26.
[34] Section 28(2) of the Constitution.
[35] Chant (2006) *Journal of Human Development* 208.
[36] C Albertyn "Contesting Democracy: HIV/AIDS and the Achievement of Gender Equality in South Africa" (2003) 29 *Feminist Studies* 595 601.

In relation to the positive recognition of difference, health care services need to recognise women's particular health care needs based on both their biology and their gender. The public health care system therefore needs to provide services that are tailored to the unique biological needs of women, without entrenching negative stereotypes. [37] This requires that health care services recognise that women are "resourceful, exercising agency and rational choices within particular contexts of vulnerability and inequality".[38] It also requires that health care services recognise that women are complex beings with shifting identities and multifaceted needs. Health care providers and health care policies therefore need to refrain from neglecting women's broader needs in favour of predominantly focusing on their roles as mothers and caregivers.[39]

However, the recognition of context, impact and difference is not enough on its own. An engendered approach also requires that the underlying purposes of the right to have access to health care services are promoted in a manner that transforms women's gendered realities. Thus, the State is required to undertake redistributive and transformative steps to ameliorate gender inequality. Health care services therefore need to entail specific positive steps that are shaped by the reality of women's lives. This should include taking steps to ameliorate the socio-economic burdens that poor women experience.[40] This necessarily requires the allocation of sufficient resources to the specific areas of women's health that are currently neglected, including GBV, maternal mortality and screening for cervical cancer. It also entails shaping health care services to suit the needs of women, and allowing women to participate[41] in shaping these services. Tailoring health care services to the specific needs of women is further justified by section 9(2) of the Constitution which defines equality to include: "The full and equal enjoyment of all rights and freedoms." It also states that in order to promote the achievement of equality, legislative and other measures designed to protect or advance persons disadvantaged by unfair discrimination may be taken. Section 9(3) of the Constitution

[37] C Albertyn "Gendered Transformation in South African Jurisprudence: Poor Women and the Constitutional Court" (2012) 22 *Stell LR* 591 604; Fredman (2009) *SAJHR* 411.
[38] Albertyn (2012) *Stell LR* 594.
[39] Albertyn (2012) *Stell LR* 603.
[40] Chant (2006) *Journal of Human Development* 206.
[41] In eviction cases such as *Port Elizabeth Municipality v Various Occupiers* 2004 12 BCLR 1268 (CC*)* and *Occupiers of 51 Olivia Road, Berea Township and 197 Main Street Johannesburg v City of Johannesburg and* Others 2008 3 SA 208 (CC); 2008 5 BCLR 475 (CC), the Constitutional Court specifically emphasised the need for parties to seek dialogic solutions to issues through mediation governed by procedural fairness. Similarly, the participation of organisations representing women's interests should also be facilitated into decision-making processes concerning health care priorities.

goes on to state that the State may not unfairly discriminate, whether directly or indirectly against anyone on the grounds of race, gender, sex or pregnancy. Given that GBV disproportionately affects women, failing to provide health care interventions and services for SGBV is therefore a form of indirect discrimination against women.

A proactive and transformative approach is further supported by international law. For example, General Comment 14 on the right to the highest attainable standard of health[42] (which is discussed in detail in chapter four),[43] specifically highlights that in order to eliminate discrimination against women; there is a need to develop a comprehensive national strategy that actively promotes women's health throughout their lifespan.[44] General Comment 14 also raises the need for particular interventions to reduce domestic violence[45] while pointing out that the realisation of women's right to health requires the removal of all barriers interfering with access to health services.[46] This could be used to bolster the argument to upgrade the existing infrastructure and to improve transport services to hospitals.

General Comment 16,[47] which concerns the equal right of men and women to the enjoyment of all economic, social and cultural rights, goes on to specifically point out that gender-neutral policies can perpetuate inequality by failing to take account of existing economic, social and cultural inequalities, particularly those experienced by women.[48] States are thus enjoined to sometimes take special measures in favour of women in order to attenuate conditions that perpetuate discrimination.[49] General Comment 16 also states that in order to guarantee that women enjoy the right to the highest attainable standard of health, States are required to remove the legal and other obstacles that prevent women from accessing health care on a basis of equality, and specifically refers to the training of health care providers.[50]

---

[42] United Nations Committee on Economic, Social and Cultural Rights, General Comment No 14 *The right to the highest attainable standard of health*, (2000) (article 12 of the Covenant) UN Doc E/C.12/2000/4 (hereafter "General Comment No 14").
[43] See the full discussion on international law in chapter four pages 99-104.
[44] General Comment 14, para 21.
[45] General Comment 14, para 21.
[46] General Comment 14, para 21.
[47] The United Nations Committee on Economic, Social and Cultural Rights, General Comment No 16 *The equal right of men and women to the enjoyment of all economic, social and cultural rights*, (2005) (article 3 of the Covenant) UN Doc E/C.12/2005/4 (hereafter "General Comment 16"). For a detailed discussion on General Comment 16 see chapter four, pages 104-105.
[48] General Comment 16, para 8.
[49] General Comment 16, para 15.
[50] General Comment 16, para 29.

It could thus be argued that in order to remove discrimination against women and to promote substantive equality, the health care response to GBV should be extended beyond a purely scientific or bio-medical health care response.[51] This is necessary as a predominantly bio-medical approach distances the health care provider from the patient, while separating social and psychological distress from physical symptoms.[52] Given the devastating psychological consequences of GBV, it is submitted that the psychological needs of SGBV require increased care and concern. The right to have access to health care services therefore needs to be interpreted holistically to include specially designed health care interventions that address all forms of GBV.[53] However, engendering health care should also entail protecting and expanding the range of feasible options available to women. This could be supported by improving access to affordable utilities such as water, sanitation, housing,[54] child-care and social security. Access to health care could similarly be facilitated through taking additional steps to ensure that women are protected from violence. In this way health care policies and services can facilitate the realisation of the right to have access to health care services on an equal basis for abused women.[55]

It is now necessary to analyse how such an interrelated interpretation which focuses on context, impact, difference and transformative values can be utilised to develop particular health care interventions for SGBV.

5 3 An interrelated approach to develop a national health care response to GBV

5 3 1 Introduction

Drawing from the above 'engendered' interpretation of access to health care services, the State is required to adopt an interventionist and context-sensitive approach to improving women's access to health care services. Developing

[51] Albertyn (2003) *Feminist Studies* 601.
[52] Joyner *Health Care for Intimate Partner Violence* 107.
[53] S Liebenberg *Socio-Economic Rights Adjudication under a Transformative Constitution* (2010) 209.
[54] General Comment 16 specifically points out that States must provide victims of domestic violence with access to safe housing in addition to redress for physical, mental and emotional damage. General Comment 16, para 27.
[55] S Liebenberg & B Goldblatt "The Interrelationship between Equality and Socio-Economic Rights under South Africa's Transformative Constitution" (2007) 23 *SAJHR* 335 335; Liebenberg *Socio-Economic Rights* 212.

interventions to address GBV is a complex process however, as there are a broad range of factors that contribute to its prevalence. For example, the World Health Organisation's World Report on Violence[56] considers violence to be a product of multiple levels of individual and societal factors. This report therefore highlights the ecological model as a tool to study and analyse the relationship between a complex interplay of individual, relationship, social, cultural and environmental factors that contribute to the prevalence of violence in a particular society. In relation to South Africa, the social dynamics that support violence include widespread poverty, unemployment, and income inequality. GBV is also exacerbated by patriarchal notions of masculinity, exposure to abuse in childhood, easy access to firearms, widespread alcohol misuse and weaknesses in the mechanisms of law enforcement.[57] The inequitable position of women, whether in a relationship or in society in general, further contributes to the prevalence of GBV. This illustrates the complexity of addressing GBV, while illustrating that a holistic systems-level approach[58] is thus required.[59]

While there are certain promising health care policies, such as the National Management Guidelines for Sexual Assault Care,[60] the policy framework on GBV is still fragmented and limited in its focus. For example, there are currently no detailed health care policies on domestic violence and human trafficking. Even where promising health care policies do exist, such policies are not being effectively implemented.[61] These shortcomings can partially be attributed to the immense challenge of attempting to transform a fundamentally unequal society. However, one cannot ignore the deeper potential problem of the State according a low priority to gender equality in our new constitutional democracy.[62] Given the extreme levels of GBV, if we are to truly recognise the inherent dignity of all women and to foster

[56] L L Dahlberg, E G Krug (World Health Organisation) "Violence - A Global Public Health Problem" in E G Krug, L L Dahlberg, J A Mercy, A B Zwi & R Lozano (eds) *World Report on Violence and Health* (2002) 1 12-13.
[57] R Jewkes "Intimate Partner Violence, Causes and Prevention" (2002) 359 *The Lancet* 1423 1426; M Seedat, A Van Niekerk, R Jewkes, S Suffl & K Ratele "Health in South Africa Violence and Injuries in South Africa: Prioritising an Agenda for Prevention" (2009) 374 *The Lancet* 1011 1011.
[58] A systems-level approach requires a collaborative multi-sectoral response between all relevant stakeholders and departments.
[59] A Morrison, M Ellsberg & S Bott "Addressing Gender-Based Violence: A Critical Review of Interventions" (2007) 22 *World Bank Research Observer* 25 41.
[60] Department of Health "National Management Guidelines for Sexual Assault Care" (2003) 1 9 <http://www.tlac.org.za/wp-content/uploads/2012/01/Sexual-Assault-Guidelines-2003.pdf> (accessed 29-04-2011).
[61] "The State of the Nation, Government Priorities & Women in South Africa" 39.
[62] Albertyn (2003) *Feminist Studies* 596.

substantive gender equality, an improved response to all forms of GBV is thus required.

5 3 2 Developing a national health care programme on GBV

The fragmented response to specific forms of GBV, such as domestic violence has been highlighted,[63] simultaneously, the issue of combating GBV has been largely omitted from health care legislation and policy. It is therefore submitted that the Department of Health needs to develop a national and holistic health care programme dedicated to the health care management of SGBV. Such a programme is necessary as there is a need for a clear and comprehensive definition of GBV and a clear statement of the rights to be applied to ensure the elimination of all forms of such violence. There is also a need for a clear commitment by the Department of Health and the State at large, in respect of its responsibilities to eliminate GBV.

This programme would need to provide services for all SGBV, including men, while prioritising the advancement of women's interests. This is necessary as men also experience GBV. The case of *Masiya v Director of Public Prosecutions Pretoria (The State) and Another,*[64] recognised this reality and subsequently extended the common law definition of rape to include the penetration of the male penis into the vagina or anus of another person. While male victims of GBV therefore need to be provided with the necessary care and treatment, it needs to be kept in mind that women are disproportionately affected by GBV, due to historic gender-based discrimination.[65] GBV also effectively entrenches existing systemic inequalities between men and women.[66] Such a policy will thus need to highlight the systemic

---

[63] B Muthren "Strategic Interventions; Intersections between Gender-based Violence and HIV/AIDS" (2004) 59 *Agenda* 93 94.

[64] 2007 5 SA 30 (CC); 2007 8 BCLR 827. Chief Justice Pius Langa (as he then was) specifically pointed out that:

> "The anal penetration of a male should be treated in the same manner as that of a female. In my view, to do otherwise fails to give full effect to the constitutional values of dignity, equality and freedom: dignity through recognition of a violation; equality through equal recognition of that violation; and freedom as rape negates not only dignity, but bodily autonomy. All these concerns apply equally to men and women and necessitate a definition that is gender-neutral concerning victims." (Para 80).

[65] B Meyersfeld *Domestic Violence and International Law* (2011) xxxv.

[66] Louise Du Toit elucidates on this point, stating that:

> "The systematic instilling of fear or terror in a clearly defined section of the population translates into power-political gain for another section of the population. Women's and children's realistic fears of sexual violence from men in general helps to create and sustain a clear gender hierarchy within South African citizenship".

See: L du Toit "A Phenomenology of Rape: Forging a New Vocabulary for Action" in A Gouws (ed) *(Un)thinking Citizenship: Feminist Debates in Contemporary South Africa* (2005) 253 254.

and entrenched nature of discrimination against women and actively promote the constitutional goal of a non-sexist society.[67] As pointed out by the Montreal Principles on Women's Economic, Social and Cultural Rights (hereafter "the Montreal principles"), acknowledging this systemic and entrenched discrimination against women is an essential step in implementing guarantees of non-discrimination and equality for women.[68] General Comment 14 further enjoins States to develop a comprehensive national strategy that actively promotes women's health throughout their lifespan.[69]

In relation to the contextual sensitivity of substantive equality, a national programme on GBV could specifically recognise and address a more holistic conception of GBV. This requires that the Department of Health recognise domestic violence, rape, including gang rapes and corrective rapes, human trafficking, female genital mutilation, stalking, harassment and witch hunts[70] as forms of GBV that require an adequate health care response. Such a programme also needs to acknowledge the less visible forms of gender inequality and how they impact upon women's health. This is necessary as non-violent practices (such as sexual harassment) have a crippling effect on women's capabilities,[71] while contributing to the atmosphere of fear in which many women live their lives.[72] Certain 'invisible' forms of domination, such as cultural pressure, can also prevent women from exercising their right to choose whether to have an abortion. As further explained by the One in Nine Campaign:

> "There is an urgent need on the one hand to expand the understanding of inter-personal violence beyond sexual violence and, on the other, to incorporate structural, cultural and systemic violence in our definition of violence that affects women, in order to fully grasp the ways in which women's lives, including HIV positive women's lives, are constricted by social codes of gendered behaviour."[73]

---

[67] Section 1(b) of the Constitution.
[68] International Federation for Human Rights, *Montreal Principles* (2002) 1.
[69] General Comment 14, para 21.
[70] Y Ally (Medical Research Council) "Witch Hunts in Modern South Africa: An Under-Represented Facet of Gender-based Violence" Fact Sheet (2009) 1 1.
[71] M Nussbaum "Women's Bodies: Violence, Security Capabilities" (2005) 6 *Journal of Human Development* 167 168.
[72] *S v Chapman* 1997 (3) SA 341 (SCA) :
> "Women in this country are entitled to the protection of these rights. They have a legitimate claim to walk peacefully on the streets, to enjoy their shopping and their entertainment, to go and come from work, and to enjoy the peace and tranquillity of their homes without the fear, the apprehension and the insecurity which constantly diminishes the quality and enjoyment of their lives."
[73] Nath "We were Never meant to Survive" (2012) 4.

A national policy on GBV could also highlight and address the impact of GBV on women's broader health care needs. For example, the national policy could highlight and address the interconnection between GBV and the HIV/AIDS epidemic in a comprehensive manner.[74] This was similarly noted by the United Nations Committee on the Elimination of Discrimination against Women, which called for the development of policies that specifically address the intersection between GBV and HIV/AIDS.[75] A national policy on GBV could further be used to highlight the interconnection between domestic violence and cervical cancer.[76] This is necessary as cervical cancer is one of the leading causes of death for women in South Africa, while predominantly affecting black women.[77]

This recognition of context, impact and difference could then inform the specific duties of the Department of Health. For example, through identifying women's specific socio-economic barriers to accessing health care services, the State could translate this information into health care programmes that broaden the feasible options available to women. For example, as highlighted in the Declaration on the Elimination of Violence against Women, States can expand services for SGBV to include child care services and maintenance.[78] Services could also be expanded to include improving transport services, such as emergency transport facilities, to hospitals. A potential national programme on GBV could further specify that it is the Department of Health's responsibility to transport complainants of GBV to health care facilities. The Department of Health can further play a role in recognising the value of caring work that women predominantly undertake and in renegotiating alternative notions of masculinity through health education. This would require cooperation and assistance from the Department of Education and the Department of Social Development.

A national health care policy on combating GBV could specifically focus on improving access to health care services for rural women through establishing more

[74] Muthren (2004) *Agenda* 93 94.
[75] United Nations Committee on the Elimination of Discrimination against Women "Concluding observations of the Committee on the Elimination of Discrimination against Women to South Africa" (2011) UN Doc CEDAW/C/ZAF/CO/4, para 36(d).
[76] A Coker, C Hopenhayn, C DeSimone, H Bush & L Crofford "Violence against Women Raises Risk of Cervical Cancer" (2009) 18 *Journal of Women's Health* 1179 1179.
[77] D Cooper, C Morroni, P Orner, J Moodley, J Harries, L Cullingworth & M Hoffmanb "Ten Years of Democracy in South Africa: Documenting Transformation in Reproductive Health Policy and Status" (2004) 12 *Reproductive Health Matters* 70 71.
[78] United Nations General Assembly Declaration on the Elimination of Violence against Women (1993) UN Doc A/RES/48/104, article 4(g).

health care clinics within rural areas, in accordance with section 36 of the National Health Act 61 of 2003 (hereafter "NHA"). The existing infrastructure would also need to be upgraded in order to protect the privacy and dignity of all patients, and particularly SGBV. This would be consistent with Sandra Fredman's conception of engendering socio-economic rights to include the restructuring of health care institutions.[79] This is further necessary in order to ensure that the other human rights of complainants of GBV, such as the right to human dignity,[80] the right to security in and control over their body[81] and the right to privacy[82] are sufficiently protected.

In order to prevent secondary victimisation and unnecessary delays, the provision of services to SGBV should also be consolidated as much as is possible. It has thus been suggested by the State, that the Thuthuzela Care centres, which offer holistic care to survivors of rape be extended to provide services to survivors of domestic violence.[83] It is submitted however, that these centres could be extended to provide services to survivors of all forms of GBV, while maintaining specialised interventions for different forms of GBV.

A national programme on GBV could furthermore specifically include strategies on training and recruiting health care providers to address the GBV epidemic, while setting out the particular human rights norms that need to be adhered to when caring for survivors of all forms of GBV. For example, the need to treat patients with sufficient dignity, kindness and respect in order to establish a relationship of trust is necessary in relation to all forms of GBV. The basic medical tenet of 'do not harm to your patient' should also apply to the health care management of all SGBV. In this regard, steps should be taken to hold health care providers responsible for failing to treat patients with the sufficient care and concern that they deserve.[84] All patients should also be kept fully informed of the services that they require and of their choices in this regard. Likewise, the State needs to facilitate women's participation in

[79] S Fredman "Engendering Socio-Economic Rights" (2009) 25 *SAJHR* 410 417.
[80] Section 10 of the Constitution.
[81] Section 12(2)(a-b) of the Constitution.
[82] Section 14 of the Constitution.
[83] Parliament of the Republic of South Africa; Research Unit "Department of Health: The Domestic Violence Act Implementation: Follow up Hearings (2012) 1 1 <http://d2zmx6mlqh7g3a.cloudfront.net/cdn/farfuture/mtime:1334233950/files/docs/120125pcwomen.pdf > (accessed 05-03-2012).
[84] *Government of the Republic of South Africa v Grootboom and Others* 2001 1 SA 46 (CC); 2000 11 BCLR 1169 (CC).The Court refers to the constitutional imperative to treat everyone with care and concern. The Court goes on to state that even if measures are statistically successful, if they fail to respond to those whose needs are most desperate, these measures may not pass the constitutional test. (Para 44).

shaping the health care services that are provided to SGBV.[85] Through such an approach, the State could develop a more gender-sensitive health care programme on GBV, while addressing the current gaps in existing health care policies.

While certain authors have suggested the strategy of 'gender mainstreaming'[86] into all existing health care policies, it is submitted that an additional core programme dedicated to GBV with a particular focus on women's health care needs is still needed, in order to sufficiently fulfil our Constitution's transformative ethos. This is due to the fact that gender mainstreaming has been criticised for its potential to simply integrate gender into existing power structures without facilitating any transformation. [87] Furthermore, the process of making gender mainstreaming everybody's responsibility has inadvertently made it no-one's responsibility.[88]

It is also important to note, that while a health care programme on GBV is necessary, such an approach does not mean that public health care services for other groups within our society should be neglected. This is illustrated by section 27(2) of the Constitution, which specifically states that reasonable measures must be taken to achieve the progressive realisation of access to health care services. This implies that the State has an on-going obligation to take reasonable measures to improve both access to health care services and the quality of health care services that are offered to everyone. [89] However, to adopt a gender-blind approach is insufficient; as it fails to recognise that the poor are not one homogenous group with identical needs. Adopting a gender-sensitive approach further highlights that men and women have specific health care needs, which require particular health care interventions.

5 3 3 Conclusion

[85] Fredman (2009) *SAJHR* 423. In eviction cases such as *Port Elizabeth Municipality v Various Occupiers 2004 12 BCLR 1268 (CC)* and *Occupiers of 51 Olivia Road, Berea Township and 197 Main Street Johannesburg v City of Johannesburg and Others* 2008 3 SA 208 (CC); 2008 5 BCLR 475 (CC) the Constitutional Court emphasised the need for parties to seek dialogic solutions to issues through mediation governed by procedural fairness.

[86] A concept which entails the incorporation of a gender equality perspective into all policies at all levels and at all stages by the actors normally involved in policy making.

[87] D Sainsbury & C Bergqvist "The Promise and Pitfalls of Gender Mainstreaming: The Swedish Case" (2009)11 *International Feminist Journal of Politics* 216 217.

[88] M A Pollack & E Hafner-Burton "Mainstreaming Gender in the European Union" (2000) 7 *Journal of European Public Policy* 432 452.

[89] Liebenberg & Goldblatt (2007) *SAJHR* 357.

The development of a national health care programme on GBV could effectively address the need for a holistic health response to GBV. Such a programme could also recognise the impact of GBV on women's broader health, such as the HIV/AIDS epidemic and cervical cancer. It could also set out the institutional and structural changes that are required in order for the health care system to adequately respond to GBV and in order to remove the gendered barriers to accessing health care services. It is within this context that such a government policy, if strategic and well-targeted, can become a powerful instrument that recognises women's particular needs while empowering women to engage with the specific challenges relating to their mental, sexual and reproductive health.[90]

Under the guidelines of a national health care programme on GBV, specific health care services and interventions could be developed in relation to specific forms of GBV, such as domestic violence and human trafficking. This is necessary as specific interventions need to be oriented towards the specific form of violence, its effect on the complainant and the social context within which it occurs.

5 4 Developing health care interventions for survivors of domestic violence

5 4 1 Introduction

Domestic violence has been highlighted as the most common form of GBV.[91] Such violence is also the most common cause of illness and disability in women around the world.[92] Despite its high prevalence and its deadly nature however, domestic violence remains incredibly difficult to address. This is partly due to its somewhat hidden nature, as it was traditionally perceived to be a 'private' form of violence. It is similarly often characterised by subtle power struggles based on economic and emotional dependency, making it difficult to fully comprehend the social, economic and psychological dynamics at play.[93] Domestic violence also carries particular health and safety risks that have implications for the design of health care

[90] L Gerntholtz & M Richter "Young Women's Access to Reproductive Health Care Services in the Context of HIV" (2002) 53 *Agenda* 99 100.
[91] L Heise & C Garcia-Moreno (World Health Organisation) "Violence by Intimate Partners" in G Etienne, L Krug, J Dahlberg, AM Anthony, B Zwi & R Lozano (eds) *World Report on Violence and Health* (2002) 89.
[92] Meyersfeld *Domestic Violence* 1.
[93] Heise et al "Violence by Intimate Partners" in Etienne et al (eds) *World Report on Violence* (2002) 89.

interventions.[94] For example, many women are at greater risk of being murdered by their partner when they attempt to leave them.[95]

The nature of domestic violence can also leave the abused too tired and depressed to seek official help.[96] The manner in which self-blame and shame contributes to the entrapment process thus requires psychological services that are tailored to the unique experiences of survivors of domestic violence.[97] Developing the law to be more responsive to the institutional and psychological barriers that abused women experience is therefore a complex process.

5 4 2 Developing a screening protocol for domestic violence

Despite its complex nature, the consequences of domestic violence trigger State responsibilities to address it. In *S v Baloyi*,[98] Justice Sachs (as he then was) effectively pointed out that section 7(2) of the Constitution, read with section 12(1) has to be understood as obliging the State to directly protect the right of everyone to be free from private or domestic violence.[99] Read with section 27(1)(a) of the Constitution, this duty should include the obligation to take steps to progressively improve services for survivors of domestic violence, and to ameliorate the devastating health consequences of such violence.

A substantive interpretation of section 9 further requires that health care interventions for survivors of domestic violence be tailored to the complexity of women's lives. For example, many impoverished abused women will stay in a relationship for economic survival. Health care interventions therefore need to be sensitive to this reality while providing abused women with information as to the options available in their specific circumstances. This necessarily requires cooperation between the Department of Health and the Department of Social Development, as the Department of Social Development is primarily responsible for providing shelters to survivors of domestic violence. In order to be effective and to respond to the socio-economic needs of women, a myriad of well- co-ordinated social interventions are thus required.

---

[94] Joyner *Health Care for Intimate Partner Violence* 74.
[95] Joyner *Health Care for Intimate Partner Violence* 74.
[96] Meyersfeld *Domestic Violence* 130.
[97] Meyersfeld *Domestic Violence* 130.
[98] 2000 2 SA 425 (CC) 2000 1 SACR 81 (CC).
[99] S *v Baloyi* 2000 2 SA 425 (CC) 2000 1 SACR 81 (CC) para 12.

In *S v Baloyi*, Justice Sachs went on to point out the impact of an ineffective criminal justice response to domestic violence, stating that it intensifies the subordination and helplessness of the complainants of domestic violence.[100] This is in contrast to the Constitutional goal to improve the quality of life of all citizens and to free the potential of each person.[101] The ineffectiveness of the health care system also causes secondary victimisation while entrenching disadvantage. He went on to state that:

> "This [the ineffectiveness of the criminal justice system] also sends an unmistakable message to the whole of society that the daily trauma of vast numbers of women counts for little. The terrorisation of the individual victims is thus compounded by a sense that domestic violence is inevitable. Patterns of systemic sexist behaviour are normalised rather than combatted. Yet it is precisely the function of constitutional protection to convert misfortune to be endured into injustice to be remedied."[102]

Health care interventions for domestic violence therefore need to be shaped by the socio-economic context of particular complainants. It is not sufficient, however, that the State simply recognises the vulnerability and disadvantage experienced by many abused women. The State also needs to provide practical remedies through services that alleviate this disadvantage. As pointed out in chapter three, South Africa currently has a progressive legislative framework on domestic violence that can be admired.[103] However, there is still room for improvement in this regard. For example, the health care needs of survivors of domestic violence could be further recognised by the legislature. Many women's rights advocates have thus recommended that the Domestic Violence Act 116 of 1998 (hereafter the "DVA") be amended to include specific positive duties on the Department of Health to assist survivors of domestic violence.[104] The DVA could therefore be amended to include a duty on health care personnel to assist and provide complainants with comprehensive health care services consonant with a human rights-based approach.

Such services could include identifying abuse, providing comprehensive clinical care, providing effective referrals and the documentation of injuries for medico-legal

[100] S *v Baloyi* 2000 2 SA 425 (CC); 2000 1 SACR 81 (CC) para 12.
[101] Preamble to the Constitution.
[102] S *v Baloyi* 2000 2 SA 425 (CC); 2000 1 SACR 81 (CC) para 12.
[103] See chapter three, pages 65-67.
[104] C Doolan "Missing Piece in the Puzzle: The Health Sector's Role in Implementing the Domestic Violence Act" (2005) 12 *SA Crime Quarterly* 9 9; "The State of the Nation, Government Priorities & Women in South Africa" 45.

purposes. This would be more consistent with the preamble to the DVA which specifically states that the purpose of the DVA is to provide survivors of domestic violence with the maximum protection that the law can provide and to convey the message that the State is committed to eliminating domestic violence.[105] Given that the health care sector has a critical role to play in the effective implementation of the DVA,[106] the inclusion of specific duties on the Department of Health would thus be more consistent with the stated purposes of the DVA.

The inclusion of specific duties on the Department of Health would also be consistent with the basic obligations induced by the socio-economic rights contained within our Constitution. For example, in the cases of *Government of the Republic of South Africa v Grootboom and Others* (hereafter *Grootboom*")[107] and *Minister of Health v Treatment Action Campaign,*[108](hereafter "*Treatment Action Campaign*") the Constitutional Court held that a reasonable programme in the context of socio-economic rights required the provision of short-term relief to those whose needs are urgent or who are living in intolerable conditions.[109] Given the high levels of domestic violence, in addition to its devastating health consequences, survivors of domestic violence are particularly vulnerable and require proactive relief. The *Grootboom* judgment further highlighted the need for comprehensive and co-ordinated programmes; while pointing out the special need for flexibility and transparency. Given the intersecting factors that contribute to the prevalence of domestic violence, health care programmes will need to be comprehensive while being coordinated to support broader social interventions. Taking positive steps would also be in line with the requirement to 'progressively realise' the right of access to health care services.

There are a range of specific health care services that should be included under the provision of comprehensive care in the DVA. For example, it could include the provision of contraception, including emergency contraception, HIV/AIDS prevention services, including screening for post-exposure prophylaxis (hereafter "PEP"), and the management of physical and psychological health care needs. The provision of such services would certainly restore some level of autonomy and power over the

[105] Preamble to the Domestic Violence Act 116 of 1998.
[106] L Vetten & T Jacobs (Consortium on Violence against Women) "Towards Developing and Strengthening a Comprehensive Response to the Health Care Needs of Rape Survivors" Policy Brief 1 4 (2008) http://www.tlac.org.za/wp-content/uploads/2012/01/developing-and-strengthening-a-comprehensive-response-to-the-health-care-needs-of-rape-survivors.pdf (accessed 14-05-2012).
[107] 2001 1 SA 46 (CC); 2000 11 BCLR 1169 (CC).
[108] (No 2) 2002 5 SA 721 (CC).
[109] *Government of the Republic of South Africa v Grootboom and Others* 2001 1 SA 46 (CC); 2000 11 BCLR 1169 (CC) paras 68& 99; Liebenberg & Goldblatt (2007) *SAJHR* 349.

abused woman's life, thus giving greater effect to the right to freedom and security of the person[110] and the right to equality.[111]

Given that a large proportion of domestic violence cases involve sexual abuse[112] and that there is an inextricable connection between HIV/AIDS and domestic violence,[113] it is submitted that abused women should also be screened to determine if they require PEP. While PEP is provided for in policy addressing the health care management of survivors of rape, a high proportion of rapes go unreported.[114] On this basis a strong case can be made out that screening for PEP, and its subsequent provision in indicated cases should be extended to survivors of domestic violence. The duty to protect women from all forms of violence,[115] read in conjunction with section 27(1) (a) and section 9(2)'s redistributive measures further justifies such an extension. The reality that special health care remedies and services are required in order to overcome the disadvantage that abused women experience,[116] further justifies this extension.

In order to extend such services, health care providers will need to be able to identify women subjected to domestic violence. Researchers have thus called upon the Department of Health to develop a comprehensive and complementary policy on domestic violence. This policy, whether it is an individual separate policy, or whether it forms of part of a national health care policy to address GBV, should set out the roles and responsibilities of health care providers, the training required by health care providers, a monitoring and evaluation strategy and the budget needed to effectively implement the policy.[117] The policy should also contain a screening protocol on domestic violence, with specific elements of care such as a referral process and a safety assessment plan. This is necessary as the current health care policy

[110] Section 12 of the Constitution.
[111] Section 9 of the Constitution.
[112] L Gerntholtz, A Meerkotter, T Meyer, J Molefe, N Nsibande & L Vetten Tshwaranang Legal Advocacy Centre "Abused Women's Rights to Access Health Care Services – A Submission to the South African Human Rights Commission Public Inquiry into the Right to have Access to Health care Services" (2007) 7 <http://www.tlac.org.za/wpcontent/uploads/2012/01/Submission-sa-human-rights-commission-abused-womens-right-to-access-health-care-services.pdf> (accessed 12-01-2012).
[113] R Jewkes, J Levin and L Penn-Kekana, "Gender Inequalities, Intimate Partner Violence and HIV Preventive Practices: Findings of a South African Cross-Sectional Study," (2003) 56 *Social Science & Medicine* 125,125; R Jewkes, K Dunkle, M Nduna and N Shai, "Intimate Partner Violence, Relationship Gender Power Inequity, and Incidence of HIV Infection in Young Women in South Africa: A Cohort Study" (2010) 367 *The Lancet* 41 41.
[114] S Roehrs "Half-hearted HIV Related Services for Victims" in L Artz & D Smythe (eds) *Should We Consent?: Rape Law reform in South Africa* (2008) 175 175.
[115] *Carmichele v Minister of Safety and Security and Another* 2001 4 938 (CC): 2001 10 BCLR 995 (CC) para 62.
[116] A Sen *Inequality Re-examined* (1992) 1.
[117] Parliament of the Republic of South Africa; Research Unit (2012) "The Domestic Violence Act Implementation" 2.

framework on domestic violence is too fragmented and does not provide clear guidelines on screening for domestic violence. There is an additional significant gap between existing health care policy and practice. For example, the Primary Health Care Package for South Africa[118] requires that:

> "A member of staff of every clinic has received training in the identification and management of sexual, domestic and gender related violence"[119]

Despite this provision, research has confirmed that health care providers often fail to recognise symptoms of GBV. For example, in a study sample of 168 women who had all experienced domestic violence, only 9.6% of these women were identified by health care providers as having experienced domestic violence.[120] Even in relation to those who had been identified, the research revealed that the documentation of injuries had been inadequate, while the women were poorly managed, particularly in relation to referrals.[121] Research undertaken by the Research Unit of the South African Parliamentary Monitoring Group also revealed that the majority of health care workers are not aware of the DVA.[122]

Introducing a protocol on screening for domestic violence is further justified on the basis that the detection of abused women is the first step towards breaking the cycle of violence and in preventing future harm.[123] In response to the need for a screening policy, the Consortium on Violence against Women (hereafter "the CVAW") developed a comprehensive protocol in 2003 entitled Screening for Domestic Violence: A Policy and Management Framework for the Health Sector (hereafter "DV policy framework").[124] This domestic violence policy framework is not an official piece of government policy and has not been adopted or recognised by the government. Rather, it is the culmination of an extensive research project undertaken by the

---

[118] Department of Health "The Primary Health Care Package for South Africa – A Set of Norms and Standards" in Department of Health Policy Documents (2000) <http://www.doh.gov.za/docs/index.html> (accessed 01-03-2011).
[119] Department of Health "The Primary Health Care Package for South Africa" (2000) 1 57.
[120] Joyner *Health Care for Intimate Partner Violence* 190.
[121] Joyner *Health Care for Intimate Partner Violence* 190.
[122] Parliament of the Republic of South Africa; Research Unit (2012) "The Domestic Violence Act Implementation" 1.
[123] M Velzeboer, M Ellsberg,C C Arcas & C García-Moreno (Pan American Health Organisation) "Violence against Women: The Health Sector Responds" (2003) 1 22 <http://www.path.org/publications/files/GVR_vaw_health_sector_fm-1-3.pdf> (accessed 04-07-2011).
[124] LJ Martin & T Jacobs (Consortium on Violence against Women) "Screening for Domestic Violence: a Policy and Management Framework for the Health Sector" (2003) <http://www.ghjru.uct.ac.za/osf-reports/protocol.pdf> (accessed 12-03-211).

CVAW entailing a comprehensive screening protocol in addition to various elements of proposed health care interventions for survivors of domestic violence. For example, the DV policy framework contains a detailed screening questionnaire in addition to a treatment plan, a safety assessment plan, effective referrals and the potential for follow-up care.

Further research on the implementation of this DV policy framework revealed that screening for domestic violence is a highly complex issue. While universal screening for domestic violence has been recommended in high resource settings, research conducted in low income countries has suggested that a case-finding approach may be more suitable. As further pointed out by Lorraine Ferris[125] and Kate Joyner,[126] a case-finding approach which is focused on addressing specific symptoms (a diagnostic method) allows for the problem of GBV to be looked for opportunistically and is more sensitive to existing resource and time constraints.

Certain health care services, such as health care for HIV/AIDS, family planning and chronic diseases may however be suited to routine screening.[127] This appears viable, as integration of screening for domestic violence in such health care services permits the expansion of basic support for abused women and children throughout the health sector. It is thus particularly important that providers of sexual and reproductive health care services and maternal health care services routinely ask women about violence and be prepared to address the specific needs of such abused women.[128] Rachel Jewkes has also suggested that the focus should shift from simply asking about domestic violence to equipping counsellors and health care providers to discuss gender inequality in relationships more broadly.[129]

While it is imperative that the health rights of women and children are not subsumed under one intervention, it is vitally important for both women and children that health care providers are trained to screen women to determine whether they have experienced domestic violence. This is due to the fact that the family plays a

[125] L Ferris "Intimate Partner Violence: Doctors Should Offer Referral to Existing Interventions, While Better Evidence is Awaited" (2004) 328 *British Medical Journal* 595 595.
[126] Joyner *Health Care for Intimate Partner Violence* 266.
[127] Joyner *Health Care for Intimate Partner Violence* 266.
[128] World Bank: A Morrison, S Bott & M Ellsberg "Addressing Gender-Based Violence in the Latin American and Caribbean Region: A Critical Review of Interventions" (2004) World Bank Policy Research Working Paper 3438 1 39 <http://siteresources.worldbank.org/INTLACREGTOPPOVANA/Resources/Morrison_Ellsbergh_Bott.pdf > (accessed 09-04-2012).
[129] N Cristofides & R Jewkes "Acceptability of Universal Screening for Intimate Partner Violence in Voluntary HIV testing and Counseling Services in South Africa and Service Implications" (2010) 22 *Aids Care* 279 279.

pivotal role in the construction of a male identity in which violence constitutes a socially sanctioned response.[130] Research has also revealed that women are particularly vulnerable to repeating the patterns of poverty, unemployment, economic dependence and domestic abuse that their mothers experienced.[131] In order to prevent or, at least mitigate, the intergenerational cycling of violence and disempowerment,[132] health care providers should therefore be trained to recognise and address domestic violence.

The 2003 DV policy framework by the CVAW also contains a section on the emotional status of the complainant. This is vital considering that emotional abuse has been highlighted as the most common form of domestic violence that is perpetrated against women.[133] Domestic violence is consequently associated with the greatest number of lifetime post-traumatic stress disorder (hereafter "PTSD") cases amongst women.[134] The neglect of such health care needs is thus insufficiently responsive to the reality of domestic violence in South Africa. It is therefore submitted that quality psychological health care services should be extended to survivors of domestic violence and that such services should be included in relevant policy. The extension of such services is not only to ensure the well-being of women. Adequate psychological health care services are also needed in order to guard against the detrimental health consequences of depression, such as the inability to adhere to the complex regiment of PEP medication. Research on the implementation of the CVAW's DV policy framework revealed that policy and programme responses to the emotional needs of complainants of domestic violence need to be broadened and tailored to the unique needs of women. This was highlighted by the DV policy framework's limited focus on emotional welfare. For example, the DV policy framework only contains four lines to address the emotional status of the complainant and has no provision for a diagnostic assessment of the complainant's mental health.[135] Through implementing the policy framework, it was revealed that this was insufficient and that a protocol on domestic violence will thus need to address the psychological and emotional needs of survivors of domestic violence in more detail.

---

[130] C Campbell "Learning to Kill? Masculinity, the Family and Violence in Natal" (1992) 18 *Journal of South African Studies* 614 617.
[131] Nath "We were Never meant to Survive" (2012) 5 15.
[132] Nath "We were Never meant to Survive" (2012) 5.
[133] M Machisa, R Jewkes, C L Morna & K Rama "The Extent of Gender-based Violence" in *The War at Home* (2010) 41 45.
[134] D Kaminer, A Grimsrud, L Myer, DJ Stein & DR Williams "Risk for Post-traumatic Stress Disorder Associated with Different Forms of Interpersonal Violence in South Africa" (2008) 67 *Social Science & Medicine* 1589 1589.
[135] Joyner *Health Care for Intimate Partner Violence* 155.

In terms of the health care management of survivors of domestic violence, Joyner went on to recommend that domestic violence be handled on a long-term basis. While one must guard against stigmatising survivors of domestic violence, adopting a long-term approach may be beneficial as, abused women can take years to leave their abusive partner due to emotional and financial dependency. The full consequences of domestic violence may also only manifest at a later stage (such as the transmission of HIV/AIDS and the development of PTSD). It is therefore submitted that health care interventions for survivors of domestic violence should be sufficiently flexible to cater for women's long-term needs while providing such women with the tools to leave abusive relationships. The DV policy framework's screening questionnaire also takes approximately 60 – 90 minutes to implement per patient.[136] Given that the primary health care system aims for a health care provider to spend an average of seven minutes with each patient, this would take too long to implement within the South African primary health care context. Joyner's research therefore recommended that if domestic violence is identified by a primary health care provider, after providing the relevant clinical care, the complainant should be referred to a domestic violence specialist, to be trained by the Department of Health.[137] This specialist should then implement the domestic violence protocol and refer the complainant to the necessary psychological, legal and social support that they require.

It is clear that such services will necessarily entail resource implications. While the South African public health care system is facing numerous crises, the health care needs of SGBV cannot be completely neglected. In the High Court case of *Western Cape Forum for intellectual Disability v Government of the Republic of South Africa and Another*,[138] the Court dealt with the provision of education to children with learning disabilities. The Court highlighted that the Government had not answered the question of why the budgetary shortfall should be borne by the children with learning disabilities.[139] In this regard, there is no reason as to why women should bear the brunt of resource limitations facing the public health care system. The High Court also specifically referred to the decision of *Government of the Republic of*

[136] Joyner *Health Care for Intimate Partner Violence* 8.
[137] Joyner *Health Care for Intimate Partner Violence* 267.
[138] (2011 (5) SA 87 (WCC)) [2010] ZAWCHC 544; 18678/2007.
[139] *Western Cape Forum for intellectual Disability v Government of the Republic of South Africa and Another* 2011 (5) SA 87 (WCC)) [2010] ZAWCHC 544; 18678/2007 para 29.

South Africa v Grootboom and Others[140] which highlighted that the concept of "progressive realisation" requires that the urgent needs of particularly vulnerable groups be prioritised.[141] Given the extreme levels of GBV, the needs of SGBV should therefore be considered within budgetary processes and decisions relating to the prioritisation of health care services. In this regard, the State should also take steps to facilitate the participation of women to allow them to shape the health care services that they would prefer to receive.

5 4 3 Conclusion

Although in many respects laudable, the above analysis has indicated that the DVA needs to be amended to include positive duties on health care providers to provide complainants of domestic violence with comprehensive health care services. Routine screening for domestic violence could also be introduced into HIV/AIDS services and reproductive health care services. In order to complement the changes to the DVA, the State needs to develop a detailed health care protocol on domestic violence that provides for the diagnostic identification of survivors of domestic violence. Thereafter such a protocol should make provision for specific health care interventions for survivors of domestic violence, including comprehensive care for physical injuries and services for the prevention of pregnancy and sexually transmitted infections. Such services should further include screening abused women to determine whether they require PEP. In order to be sufficiently responsive to the needs of abused women, the State needs to also provide quality psychological care to treat and prevent possible depression and PTSD. Counselling may further be required for HIV-positive women and for women who need to receive an abortion. In order to be comprehensive, the protocol should necessarily include a safety assessment plan, while making provision for the detailed recording of the complainant's injuries for medico-legal purposes. In this manner the State can draft and implement a holistic and comprehensive health care policy on domestic violence that is far more responsive to the needs of abused women.

5 5 Developing health care interventions for survivors of sexual violence

[140] 2001 1 SA 46 (CC); 2000 11 BCLR 1169 (CC).
[141] *Government of the Republic of South Africa v Grootboom and Others* 2001 1 SA 46 (CC); 2000 11 BCLR 1169 (CC) para 44.

5 5 1 Introduction

Rape has been highlighted as a devastating experience. The social stigma that attaches to rape provides an additional obstacle to gaining the necessary support and assistance that a survivor of rape requires.[142] As further pointed out by the South African Supreme Court of Appeal:

> "Rape is a very serious offence, constituting as it does a humiliating, degrading and brutal invasion of the privacy, the dignity and the person of the victim. The rights to dignity, to privacy, and the integrity of every person are basic to the ethos of the Constitution and to any defensible civilization."[143]

It is submitted that the health care response to rape should therefore be more responsive to this reality. While the need for a holistic health care response to rape has been consistently highlighted in research,[144] the health care needs of survivors of rape have been consistently neglected.

5 5 2 Amending the Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007

The limitations of section 28[145] of the Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007 (hereafter the "SOA") have already been discussed in detail in chapter three.[146]

---

[142] Gerntholtz & Richter (2002) *Agenda* 100.
[143] *S v Chapman* 1997 (3) SA 341 (SCA) para 344J.
[144] N Abrahams & R Jewkes "Barriers to Post Exposure Prophylaxis (PEP) Completion after Rape: A South African Qualitative Study" (2010) 12 *Culture, Health & Sexuality* 471 471.
[145] Section 28 states that:
(1) If a victim has been exposed to the risk of being infected with HIV as the result of a sexual offence having been committed against him or her, he or she may—
(a) subject to subsection (2)-
(i) receive PEP for HIV infection, at a public health establishment designated from time to time by the cabinet member responsible for health by notice in the *Gazette* for that purpose under section 29, at State expense and in accordance with the State's prevailing treatment norms and protocols;
(ii) be given free medical advice surrounding the administering of PEP prior to the administering thereof; and
(iii) be supplied with a prescribed list, containing the names, addresses and contact particulars of accessible public health establishments contemplated in section 29(1)(a); and
(b) subject to section 30, apply to a magistrate for an order that the alleged offender be tested for HIV, at State expense.
(2) Only a victim who—
(a) lays a charge with the South African Police Service in respect of an alleged sexual offence; or

It is submitted that the provisions within the SOA that limit access to PEP (section 28(1)(a) read with section 28(2)) should be removed, while the health rights of complainants of rape in terms of section 28(1) (a)(i-iii) should be broadened.

The removal of section 28(2) is necessary as rape has reached extreme levels, while effectively intersecting with, and compounding the HIV/AIDS epidemic. It is further necessitated by the fact that section 28 primarily concerns women who cannot afford to pay for medical services. Limiting PEP will thus ultimately entrench the disadvantage predominantly experienced by poor black women. In light of our constitutional goals to achieve a society based on non-sexism and non-racism, this limitation is unreasonable and unjustifiable. The particular needs of socio-economically vulnerable groups was further pointed out in the case of *Minister of Health v Treatment Action Campaign*,[147] where the Court stated that when drafting health care policy, the State needs to take into account the differences between those who can afford to pay for services and those who cannot.[148] The need to address inequitable access to health care services has also been highlighted in international law by General Comment 14 on the highest attainable standard of health. General Comment 14 specifically states that States have a special obligation to provide those who do not have sufficient means to access health care services with the necessary health insurance and health care facilities that they require.[149] The Montreal principles further state that States are required to repeal laws and policies that discriminate either directly or indirectly against women. States are also required to remove any obstacles that prevent women or certain groups of women from accessing institutions which implement women's economic social and cultural rights.

Most importantly, the survivor's decision regarding the involvement of the South African Police Services should be respected at all times. This is particularly necessary as rape is highly under-reported,[150] indicating that many women do not wish to report their experience of rape. While the criminal justice system and the health care system response to GBV should be progressively improved so as to encourage greater reporting of GBV, women should not be forced to report their

---

(b) reports an incident in respect of an alleged sexual offence in the prescribed manner at a designated health establishment contemplated in subsection (1)(a)(i), within 72 hours after the alleged sexual offence took place, may receive the services contemplated in subsection *(*1)(*a).*

[146] See chapter 3, pages 79-80.

[147] (No 2) 2002 5 SA 721 (CC).

[148] (No 2) 2002 5 SA 721 (CC) para 70.

[149] General Comment 14,para 19.

[150] Roehrs "Half-hearted HIV Related Services" in *Rape Law Reform* 175.

experiences when their human rights may not be guaranteed. The Tshwaranang Legal Advocacy Centre (hereafter "TLAC") has thus recommended that in order to access holistic health care services for rape, the only requirement for reporting in terms of the SOA should be that a survivor simply requests sexual assault services at a designated health establishment.[151] Not requiring the patient to first report the rape is consistent with the NHA and the Charter of patients' rights, which provides for the participation of the patient in any health care treatment and management.[152] While the Charter of patient's rights is not a law, it does set out guidelines which health care workers and patients are expected to follow. The provision that a survivor of rape may simply request sexual assault services would also be consistent with the National Management Guidelines for Sexual Assault Care, [153] while affording complainants of sexual offences "the least traumatising protection that the law can provide".[154]

Section 28 should correspondingly be broadened to include the duty on the Department of Health to provide psychological health care services to survivors of rape. In 2006 the TLAC specifically recommended that the Criminal Law (Sexual Offences and Related Matters) Amendment Bill [B-2006] (as it then was) be broadened to include a provision that survivors of rape would be entitled to "appropriate medical care, treatment and counselling, as may be required for such injuries" at State expense.[155]

Such a provision is necessary as studies highlight that counselling and support are an integral component of a PEP service.[156] Rape is also one of the most pathogenic

---

[151] National Working Group on Sexual Offences "Submission to the Department of Justice: Regulations in terms of the Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007" (2008) 5 <http://www.tlac.org.za/wp-content/uploads/2012/01/nwgso-submission-on-sexual-offences-act-regulations.pdf> (accessed 15-04-2012).

[152] Section 8(1) of the National Health Act 61 of 2003 states that a health care user has: "The right to participate in any decision affecting his or her personal health and treatment," while the Patient's Rights Charter specifically states that:

> "Every citizen has the right to participate in the development of health policies and everyone has the right to participate in decision-making on matters affecting one's health."

[153] Department of Health "National Management Guidelines for Sexual Assault Care" (2003) 1 9 <http://www.tlac.org.za/wp-content/uploads/2012/01/Sexual-Assault-Guidelines-2003.pdf> (accessed 29-04-2011).

[154] Section 2 of the Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007 (hereafter the "SOA").

[155] L Gerntholz, A Meerkotter, T Meyer, N Mkhuma, J Molefe, N Nsibanda & L Vetten "Submission to the Commission on Gender Equality: Criminal Law (Sexual Offences and Related Matters) Amendment Bill [B-2006]" (2006) 6 <http://www.tlac.org.za/wp-content/uploads/2012/01/commission-for-gender-equality-tlac-submission-sexual-offences.pdf > (accessed 12-05-2011).

[156] L Vetten & S Haffejee, "Supporting Rape Survivors in Adhering to Post-Exposure Prophylaxis (PEP) to Prevent HIV Infection: The Importance of Psychosocial Counselling and Support" (2008) 23 *The Southern African Journal of HIV Medicine* 1 4.

forms of violence with regard to PTSD.[157] A commitment to substantive gender equality further requires sufficient recognition of the stigma, vulnerability and disadvantage experienced by complainants of rape, and the taking of proactive steps to ameliorate this stigma as much as is possible. By failing to provide comprehensive health care that includes psychological health care within the SOA, the disadvantage and vulnerability experienced by many survivors of rape is thus effectively ignored and compounded. This is deeply counter-intuitive to the constitutional commitment to improve the quality of life of all citizens and free the potential of each person[158].

In order to be more responsive to the needs of survivors of rape, the psychological management of such women also needs to be tailored to the unique needs and experiences of each individual woman, as far as is possible. This requires that such complainants are informed of their rights, and of the examination that they will receive. Given that rape frequently results in long-term health consequences such as depression and PTSD, survivors of rape may therefore need to be treated on a long-term basis.

Submissions to the South African Law Reform Commission (hereafter the "SALC") in 2002 recommended that positive legal duties be placed on health care workers within the SOA in relation to the standard and quality of health care services provided to survivors of rape.[159] It was further recommended that these duties should be accompanied by a set of regulations developed in terms of the SOA by the Department of Health.

It must be recognised that the 2003 National Management Guidelines for Sexual Assault Care and the 2005 National Sexual Assault Policy, provide a detailed list of duties that health care providers are expected to adhere to.[160] However, basic infrastructure and policy directives have not been introduced in accordance with

---

[157] D Kaminer, A Grimsrud, L Myer, DJ Stein & DR Williams "Risk for Post-traumatic Stress Disorder Associated with Different Forms of Interpersonal Violence in South Africa" (2008) 67 *Social Science & Medicine* 1589 1590.

[158] Founding provisions of the Constitution.

[159] South African Law Commission "Project 107: Sexual Offences Report" (2002) 1 333 <http://www.justice.gov.za/salrc/reports/r_prj107_2002dec.pdf.> (accessed 12-05-2011).

[160] For example, the National Management Guidelines for Sexual Assault states that all health care providers should be able to:

> "Recognise physical and sexual assault, document pertinent history, perform a thorough head to toe physical examination, document all injuries, collect forensic evidence as prescribed in the SAECK(Sexual Assault Evidence Collection Kit), provide pre and post-test counselling for HIV, screen for STI and HIV, treat physical injuries, prevent unwanted pregnancy, prevent and treat STIs, provide post exposure prophylaxis for HIV, provide psychological support, refer to appropriate resources, complete the J 88 form in police cases and present evidence in court."(p 12).

these provisions.[161] The submissions to the SALC further pointed out that guidelines and policies are often unenforceable and that there is limited recourse where the guidelines are not adhered to.[162] Research has further illustrated that many health care providers fail to adhere to these guidelines,[163] while certain health care providers have not been adequately trained on treating survivors of rape.[164] Placing positive duties on health care providers within the SOA may therefore be necessary in order to uphold the standard of care that is provided. Due to the reality that most rapes are committed by someone that is known by the complainant, it may also be necessary to conduct a more detailed safety assessment plan when providing health care services to complainants of rape.

Such interventions will necessarily entail resource implications. However, by providing quality psychological health care services, the State may assist survivors of rape in adhering to the PEP regiment. This will ultimately save resources by ensuring that the PEP regime is more effective and in preventing the spread of HIV/AIDS. Furthermore, given that South Africa has been described as the 'rape capital of the world', the needs of a particularly vulnerable group cannot be completely neglected on the basis of 'lack of available resources'.[165]

5 5 3 Conclusion

Ultimately, the State needs to amend the SOA to include positive duties on health care providers, while removing section 28(1)(a) and section 28(2)) of the SOA. The State also needs to implement the existing 2003 National Management Guidelines for Sexual Assault Care and the 2005 National Sexual Assault Policy. To complement this, section 28(1) of the SOA should further be broadened to include comprehensive psychological care for survivors of rape. Most importantly the constitutional rights to equality, access to health care services and human dignity require that women who are raped are provided with comprehensive health care services that alleviate their disadvantage and trauma.

---

[161] South African Law Commission "Sexual Offences Report" (2002) 334.
[162] South African Law Commission "Sexual Offences Report" (2002) 334.
[163] L Vetten, J Kim, E Ntlemo & L Mokwena "From Paper to Practice: Lessons in the Implementation of Health and Victim Empowerment Policy Applicable to Rape Survivors" (2009) *Policy Brief 2 2* <http://www.tlac.org.za/wp-content/uploads/2012/01/Policy-Brief-from-paper-to-practice.pdf> (accessed 12-04-2012).
[164] Vetten et al (2009) *Policy Brief 2* 2.
[165] *Government of the Republic of South Africa v Grootboom and Others* 2001 1 SA 46 (CC); 2000 11 BCLR 1169 (CC) para 44.

5 6 Training health care providers to recognise GBV as a public health care issue

As was highlighted in chapter three, deeply entrenched patriarchal views play a particular role in preventing women from accessing health care services on an equal basis.[166] For example, in a 2005 research study conducted by Rachel Jewkes and Nicola Cristofides, lay HIV/AIDS counsellors were trained to offer universal screening for domestic violence to HIV positive women.[167] They were tested both before and after training to determine whether their attitudes regarding domestic violence had changed. The tests revealed that although there were some improvements after training, some counsellors were openly resistant to reflecting on their gender attitudes. Certain counsellors even appeared to have further entrenched their conservative gender attitudes.[168] This reveals the extent of the work that is required in order to transform deeply entrenched negative attitudes towards women.

Health care providers also have entrenched beliefs regarding rape. This was illustrated in a national survey which revealed that 32.6 % of health care providers did not consider rape to be a serious medical condition.[169] In this study certain health care providers specifically mentioned that women are raped when they are drunk and that women cannot always be believed about rape.[170] These underlying attitudes reveal the more general cultural message that women will be held responsible for the way that men treat them. [171]

Given that health care workers effectively act as gatekeepers to the health care system, health care providers need to be sufficiently trained in order to recognise the broader social context of GBV and gender inequality in South Africa. Training primary health care providers to identify and deal with GBV is an additional necessary step in shifting the underlying social and cultural structures that facilitate gender inequality.[172] As further pointed out by Bonita Meyersfeld: “It is within the context of

[166] See: chapter 3, page 70.
[167] Cristofides & Jewkes (2010) *Aids Care* 279.
[168] Cristofides & Jewkes (2010) *Aids Care* 283.
[169] N Christofides, R Jewkes, N Webster, L Penn-Kekana, N Abrahams & L J Martin “Other Patients are Really in Need of Medical Attention’- The Quality of Health Services for Rape Survivors in South Africa” (2005) 83 *Bulletin of the World Health Organisation* 495 495.
[170] Christofides et al (2005) *Bulletin of the World Health Organisation* 497.
[171] R Jewkes & R Morrel “Sexuality and the Limits of Agency among South African Teenage women: Theorising Femininities and their Connections to HIV Risk Practises” (2012) 74 *Social Science & Medicine* 1729 1730.
[172] Meyersfeld *Domestic Violence* 184.

ignorance and apathy that violations are made possible."[173] Training of health care providers is also in line with international law standards, with international instruments consistently calling for the training of health care providers.[174] The Convention on the Elimination of all forms of Discrimination against Women (hereafter "CEDAW") specifically enjoins States to:

> "Take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning."[175]

The manner in which health care providers often cause secondary victimisation for SGBV was raised as a key issue at the parliamentary hearings in January 2012 on the effective implementation of the Domestic Violence Act.[176] In the report from the hearings, it was specifically recommended that Government personnel who are providing psycho-social health care be audited to determine exactly where the skills shortages lie. It was further recommended that a strategic plan be developed to address this shortfall, such as offering bursaries for social workers and forensic nurses.[177]

Of particular importance, is the need for health care providers to recognise the complex and shifting identities that women experience. For example, as pointed out by Rachel Jewkes, while it is true that women are subjected to certain patriarchal constraints, they are not passive victims. Women are constantly making strategic choices within the limited options available to them.[178] In this regard, Sally Engel Merry attempts to explain the reasons behind why battered women appear to utilise the legal system and then subsequently withdraw. She speaks of the shifting identities that women encounter. On the one hand women are defined by family, kin and work relationships. By seeking to rely on the legal system however, women are defined as autonomous and reasonable beings entitled to certain protections from

---

[173] Meyersfeld *Domestic Violence* 184.
[174] Paragraph 106(q) of the Beijing Declaration and Platform for Action (1995) UN Doc A/CONF.177/20; paragraph 24(b) of General Recommendation No 19 *Violence against Women* (1992) (article 3 of the Convention) UN Doc A/47/38; paragraph 15(b) of general recommendation No 24 *Women and Health* (1999) (Article 12 of the Convention) UN Doc A/54/38/Rev.1chap1 and paragraph 33 of the European Recommendation on the Protection of Women against Violence.
[175] Article 12 (1).
[176] Parliament of the Republic of South Africa; Research Unit (2012) "The Domestic Violence Act Implementation" 1 1.
[177] Parliament of the Republic of South Africa; Research Unit (2012) "The Domestic Violence Act Implementation" 1 2.
[178] Jewkes & Morrel (2012) *Social Science & Medicine* 1735.

the State. If they appear to lose more by relying on the State (if their abuse is trivialised), than by staying with their abusive partner (often appeasing their family) then they will subsequently withdraw from the legal system and revert back to their former identity with which they are more secure. This reveals the integral importance of the legal system in reconfiguring subjective identities and in reaffirming autonomous conceptions of the self as entitled to human rights.[179] It also reveals the vital responsibility of health care personnel and police personnel in providing supportive services and in refraining from causing secondary victimisation to women that have been abused.[180]

A transformatory approach thus requires training health care providers to recognise the socio-economic constraints that shape women's choices while seeking to broaden their options. This needs to be done without treating them in a stereotypical manner as victims or as scapegoats. The recognition of this also allows health care providers to be trained to take into account the emotional and relational motivations for women's behaviour in a supportive manner.[181] This is particularly important in relation to HIV/AIDS and GBV interventions, where women may have specific emotional and social motivations for remaining in an abusive relationship or for taking sexual risks. This approach is further consonant with a substantive equality perspective which recognises the need to facilitate women's participation in shaping their own particular health care needs.[182]

The training of health care providers is further necessary as the health care system is often the only point of entry into the formal legal system for many survivors of GBV. The impact of a health care provider's reaction to GBV should also not be underestimated. For example, responding in a judgmental way to a survivor of domestic violence can result in severe psychological damage to an abused woman.[183] It has also been pointed out that the clear indication to patients that violence is not a taboo subject is in itself a vital therapeutic component of any intervention.[184] Training health care providers to adequately deal with GBV is thus vital.

---

[179] S E Merry "Rights Talk and the Experience of Law: Implementing Women's Human Rights to Protection from Violence" (2003) 25 *Human Rights Quarterly* 343 351.
[180] Merry (2003) *Human Rights Quarterly* 351.
[181] Jewkes & Morrel (2012) *Social Science & Medicine* 1736.
[182] Fredman (2009) *SAJHR* 417.
[183] T Randall "Domestic Violence Interventions Call for More than Treating Injuries" (1990) 264 *Journal of the American Medical Association* 939 940.
[184] N Chescheir "Violence against Women: Responses from Clinicians" (1996) 27 *Annals of Emergency Medicine* 765 766; Joyner *Health Care for Intimate Partner Violence* 96.

However, as already pointed out, training health care providers to recognise and deal with GBV may not in itself be enough to alter negative and entrenched sexist attitudes. While all health care providers should be trained to recognise GBV, it has been recommended that certain health care providers should be selectively chosen to recognise and 'champion' the health care needs of SGBV, while being responsible for over-seeing the institutionalisation and the implementation of a national health care policy on GBV.[185]

As pointed out by Sandra Fredman, the training of these leaders is necessary, as the effectiveness of such strategies depends on convincing those who implement the plan of its appropriateness and value and on ultimately changing the institutional culture itself.[186] In contrast to simply exercising unilateral control, she goes on to state that more can be achieved by enlisting the self-interest of providers and by facilitating their participation in decision making processes.[187] She warns however, that simply harnessing the energy of the provider is not enough in itself. The quality of such regulation improves significantly when those who are affected are incorporated into the decision-making process.[188] This therefore highlights the need for participation of both health care providers and abused women in designing and implementing a programme on GBV.

The training of health care providers should also be linked to changes throughout the health care institution. For example, training should be accompanied by complementary alterations to infrastructure, existing policies, procedures and resource distributions.[189] Kate Joyner thus recommends the simultaneous alteration of health care documents, such as hospital admission forms, so as to include an inquiry into experiences of violence. [190]

While research has primarily been aimed at screening for domestic violence, it is submitted that training of health care providers should be extended to include training on the health care needs of all women who have experienced GBV. In order to be effective, the national health care programme on GBV and the subsequent training of health care providers needs to be complemented by the development of an effective information system.

---

[185] Joyner *Health Care for Intimate Partner Violence* 277.
[186] S Fredman "Rights and Remedies: The Limits of the law" in S Fredman *Discrimination Law* (2011) 278 317.
[187] S Fredman "Rights and Remedies" in *Discrimination Law* (2011) 317.
[188] Fredman "Rights and Remedies" in *Discrimination Law* 318.
[189] Morrison et al (2007) *World Bank Resolutions and Observations* 36.
[190] Joyner *Health Care for Intimate Partner Violence* 91.

5 7 Developing an effective information system

Certain forms of GBV, such as sexual harassment, corrective rapes and human trafficking have been rendered invisible within our society. The State therefore needs to develop an effective systemised information system within and across government departments including the Department of Health, the Department of Education and the Department of Safety and Security.[191] The Department of Health has a particularly important role to play in this regard as health care providers are effectively the gatekeepers in efforts to monitor, identify, treat and intervene in many cases of GBV.

The development of an effective information system is supported by international law, with General Comment 14 specifically pointing out that in order to identify gender inequalities in health; States should disaggregate health and socio-economic data in health related policy frameworks.[192] The Special Rapporteur on Violence against Women has further pointed out that in order to be effective, health care interventions designed for SGBV need to be based on accurate empirical data.[193] The lack of gender-disaggregated data on GBV and women's particular health care needs has further been highlighted as a severe obstacle in measuring government performance. As further pointed out by the Women's Legal Centre:

> "This persistent unavailability of gender-disaggregated information makes a mockery of government's declared commitment to gender equality, as it is impossible for government programmes to target the multiple challenges women face if no data is available to inform those programmes."[194]

While the government has recommended that an effective information system be developed specifically in relation to domestic violence,[195] it is submitted that an effective information system needs to be developed in relation to all forms of GBV. This would aid in identifying the prevalence of other under-acknowledged forms of

[191] "The State of the Nation, Government Priorities & Women in South Africa" 3.
[192] General Comment 14, para 20.
[193] Y Ertürk, United Nations Special Rapporteur on Violence against Women "The Due Diligence Standard as a Tool for the Elimination of Violence against Women: Report of the Special Rapporteur on Violence against Women, Its Causes and Consequences" (2006) UN E/CN.4/2006/61, para 37.
[194] "The State of the Nation, Government Priorities & Women in South Africa" 5.
[195] Parliament of the Republic of South Africa; Research Unit (2012) "The Domestic Violence Act Implementation" 1.

GBV, such as corrective rapes, female genital mutilation and human trafficking. This is also in line with international standards, as the Declaration on the Elimination of Violence against Women specifically states that States need to "promote research, collect data and compile statistics,"[196] on the prevalence of different forms of GBV. States are also encouraged to research the causes, nature, seriousness and consequences of GBV and the effectiveness of measures implemented to prevent and redress GBV.

Given that cooperation between different levels of government is particularly important in relation to combating human trafficking, an effective information system could also serve to monitor the prevalence of human trafficking in South Africa. An information system could additionally track the trends and incidences of other forms of GBV as it relates to specific demographics and to other intersecting axes of disadvantage. An effective information system can further foster the necessary cooperation that is required for an effective multi-sectoral response to GBV.

This database can also be utilised to identify and refer SGBV to necessary and appropriate psychosocial services. It could also be used to effectively disseminate vital information on health care services to health care workers and SGBV, thus addressing the fact that many women are not even aware of the existence of the SOA.

5 8 Conclusion

The health care system is clearly neglecting many of the most urgent health care needs of SGBV. Simultaneously, there is often a substantial gap between existing policy and practice, with health care providers consistently failing to comply with such policies. Given the extreme levels of GBV, infusing health care services with substantive equality is therefore necessary in order to transform systemic gender inequality in South Africa and to affirm the inherent value of all women. Engendering health care services has the additional potential to broaden the limited understanding of reproductive justice to include a more substantive vision of redistributive justice in relation to women's health care needs.

In order to infuse the right to have access to health care services with the right to equality, the State needs to recognise the historical and current social context of

[196] DEVAW, article 4(k).

gender inequality in South Africa. In this regard the State needs to recognise how GBV entrenches existing gendered hierarchies, while recognising a more holistic conception of GBV. The State also needs to address the gendered impact of inadequate services on women, while positively recognising the differences between the genders. The State further needs to take concrete steps to ameliorate women's actual material and social disadvantage. Most importantly, in order to transform women's gendered realities, the State needs to play a proactive role in providing good quality social services and in facilitating access to health care services for abused women.[197]

Achieving these goals requires the Department of Health to develop a comprehensive national programme on GBV, with a particular focus on advancing the rights of women. Within this programme the State can recognise the historical and social context of entrenched gender inequality within South Africa and how it manifests into various forms of GBV. Under this national programme the State can also set out its strategies to improve social services so as to alleviate the devastating consequences of such violence.

Under this programme, the Department of Health needs to further develop particular health care interventions for specific forms of GBV, such as domestic violence, rape and human trafficking. A transformative approach to GBV necessarily requires recognition of the fact that in order to address the systemic nature of gender inequality, positive steps are necessarily required. The DVA and the SOA could therefore be amended to place positive duties on health care providers to provide quality and humane health care services to SGBV.

This can be complemented by the improvement of the existing infrastructure so as to facilitate increased privacy and protection for SGBV. Health care providers will also need to be adequately trained if the State is to address the deeply entrenched social and cultural beliefs that justify the ill treatment of women. In this regard infusing health care services with a substantive equality perspective may assist health care providers in understanding that a woman's health is inextricably tied to the wider social, economic and political conditions of her life.[198]

Simultaneously, the State needs to develop a comprehensive information system in order to generate and collect gender-disaggregated data on the prevalence and

[197] Liebenberg *Socio-Economic Rights* 209.
[198] Guedes et al (2002) *Health and Human Rights* 189.

consequences of GBV. Such information then needs to be publicised so as to empower abused women and health care providers.

It is clear that such measures will need to be coupled with budgetary allocations. While the South African public health care system is facing various crises, the health care needs of abused women cannot be ignored. This is due to the extremely high prevalence of GBV, in addition to the Constitutional Court's affirmation that the needs of the most vulnerable members of our society cannot be neglected within government policy.[199] In order to facilitate women's participation in shaping health care services, the State will also need to be more transparent in relation to such budgetary allocations.

What is clear therefore is that the State and the Department of Health are both presented with a unique opportunity and challenge, to recognise, and subsequently transform the on-going pervasiveness of gender inequality, and GBV within our society. It is further clear that if positive steps are taken by the Department of Health, the health care response to GBV could be effectively transformed to be more responsive to the health care needs of survivors of all forms of GBV.

[199] *Government of the Republic of South Africa v Grootboom and Others* 2001 1 SA 46 (CC); 2000 11 BCLR 1169 (CC) para 44.

6 Conclusion

6 1 Introduction

This thesis set out to explore how existing law and policy could be transformed to be more responsive to the needs and circumstances of survivors of gender-based violence (hereafter "GBV"). During the course of this thesis, it became clear that there are certain features of our legal system that effectively constrain the ability of the law to respond effectively to gender inequality and GBV in our society. For example, judicial interpretations of the constitutional rights have at times been unduly formalistic. This has consequently perpetuated the disconnection between the law and the lived realities of women. Existing health legislation and policy further demonstrates this disconnection, with most health care legislation and policies choosing to adopt the 'women as mothers' approach. The broader health care needs of women, such as services for survivors of GBV (hereafter "SGBV") and screening for cervical cancer are therefore effectively 'missing' from health care legislation and policy. An analysis of international law obligations, as normative markers, further revealed that South Africa's public health care system is failing to adhere to international standards. This is particularly in relation to the requirement that health care services need to be made available, accessible, acceptable and of a decent quality, on a basis of equality.[1]

Using the normative framework developed in chapters two and three, it is thus clear from all of the above that the State can and must take positive steps to engender the law so as to bridge the disconnection between the law and women's lived reality. The purpose of this concluding chapter is thus to highlight some important recommendations and reflections as to the nature of the positive steps that are required by the State.

6 2 Recommendations

In this section, I highlight some of the implications and recommendations emerging from the analysis in the various chapters of this thesis. The thesis commenced with an overview of the relevant jurisprudence on the socio-economic rights and the right

[1] General Comment No 14, paras 12(a)-12(d).

to equality in South Africa. It was argued in chapter two, that existing judicial interpretations of the right to equality and the right to have access to health care services have at times been unduly formalistic. For example, certain interpretations of the right to equality have ignored the feminisation of socio-economic burdens. The courts have also often inadvertently entrenched conservative and stereotypical ideas on gender and sexuality.[2] In relation to the interpretation of the socio-economic rights, women have largely been absent from the majority of these cases, despite the feminisation of poverty.[3] While the right to have access to health care services for women was considered in *Minister of Health and Others v Treatment Action Campaign and Others,*[4] the Court primarily focused on women as mothers. This perpetuated the stereotypical notion that women are only child-bearers and nurturers, while failing to develop a more nuanced understanding of the intersecting axes of gender, race and class.

Chapter two concluded that both the socio-economic rights and the right to equality need to be interpreted substantively and as mutually reinforcing. Interpretations of the right to have access to health care services therefore need to be more sensitive to the social context of gender inequality and GBV in South Africa. Interpretations of this right also need to be more responsive to the impact of inadequate services on women, while facilitating a more positive recognition of gendered differences. Furthermore, such decisions need to focus on transforming existing systemic gender inequalities. An interrelated approach is thus recommended in order for the law to be more responsive to the reality of women's lives. This approach has the additional potential to trigger a stricter standard of scrutiny in relation to the State's defence of 'a lack of available resources' in failing to implement the constitutional right to have access to health care services.

In relation to unfair discrimination cases, a deeper engagement with material deprivation as it relates to social disadvantage would assist in preventing the conflation of the right to dignity and the right to equality. An interrelated approach would further aid in eradicating poverty (economic equality) while affirming diverse human identities and capabilities (social equality)."[5] This would further assist in

[2] C Albertyn "Substantive Equality and Transformation in South Africa" (2007) 23 *SAJHR* 253 255.
[3] C Albertyn "Gendered Transformation in South African Jurisprudence: Poor Women and the Constitutional Court" (2012) 22 *Stell LR* 591 600.
[4] (No 2) 2002 5 SA 721 (CC); 2002 10 BCLR 1033 (CC).
[5] C Albertyn & B Goldblatt "Equality in the Final Constitution" in S Woolman, T Roux & M Bishop (eds) *Constitutional Law of South Africa* 2 ed (Original Service June 2008) 35-1 1.

enriching the law's responsiveness to the intersecting nature of disadvantage and the mutually reinforcing patterns of poverty and gender inequality.

During the course of chapter three it became clear that South Africa's health legislation and policy framework suffers both from implementation challenges and critical gaps pertaining to women's health care needs. For example, there are currently insufficient health care interventions to identify and treat SGBV. Furthermore, the Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007 contains unnecessary obstacles to the provision of post-exposure prophylaxis (hereafter "PEP") and does not contain a broader section relating to the general health care management of rape survivors. The broader health care needs of women, such as screening for cervical cancer are also neglected, while there is insufficient transparency relating to the budgetary allocations for services for SGBV.[6]

This chapter highlighted the critical imperative to improve implementation of existing health legislation, such as the National Health Act 61 of 2003. The policy paper on the proposed National Health Insurance system also needs to be reviewed so as to be infused with women's particular health care needs.[7] The ability of the NHI system to extend current health care services to cater for women's specific health care needs will further depend on the State's ability to address the human resource crisis currently facing the public health care system.[8] As pointed out by Rebecca Amollo, the political debate currently surrounding the NHI system could be used to strategically ensure that women's health care needs enter the public debate and receive increased attention and prioritisation.[9]

In relation to SGBV, there is a need to upscale treatment for survivors of rape, while health care interventions need to be developed for survivors of other forms of GBV, such as survivors of domestic violence and survivors of human trafficking.

Chapter four explored existing international law instruments relating to the right to health. This chapter highlighted that South Africa needs to address the quality of health care services that are currently being offered within the public health care system. It also highlighted the need to 'engender' existing health care programmes and policies and the need to prioritise the needs of specific groups, such as women and children. With regard to health care for SGBV, the international law examined

[6] D Budlender & J Kuhn (Centre for the Study of Violence and Reconciliation) "Where is the Money to Address Gender-Based Violence?" (2007) 1 4.
[7] R Amollo "The National Health Insurance Policy: What's in it for Women's Health?" (2012) 92 *Agenda* 111 121.
[8] Amollo (2012) *Agenda* 113.
[9] Amollo (2012) *Agenda* 113.

sets specific standards in relation to health care for SGBV which are binding on States Parties to the relevant treaties. Such standards include recognising the systemic nature of gender equality, while taking positive steps to progressively target women's specific health care needs. For example, States are obliged to take steps to improve maternal health care services,[10] while developing specific health care interventions to identify and prevent forms of GBV, such as domestic violence.[11] The CEDAW Committee has further supported the development of national legislation and policies that address a more holistic conception of GBV.[12]

The CEDAW Committee has also called for the adequate training of health care providers so as to be able to recognise and care for abused women,[13] in addition to the development of adequate support services so as to provide trauma services, counselling and rehabilitation for SGBV.[14] Under both UNESCR and the CEDAW Committee, States are obliged to protect the rights to be free from non-consensual medical treatment, such as forced sterilisations.[15] Decisions under treaty supervisory bodies, such as the CEDAW Committee have also pointed out that States may be held accountable for the violations of the right to health perpetrated by private actors, including health care workers and police personnel.[16]

This chapter further elaborated on the 'due diligence' obligation of South Africa to prevent and respond to GBV. Part of this obligation entails taking reasonable positive steps to facilitate access to health care services for SGBV, and to offer adequate reparation in the form of gender-sensitive health care services for SGBV.

Using the normative framework developed in chapter two and three and the standards articulated in international law, it is clear that the Department of Health is obliged to develop a comprehensive national programme on GBV, with a particular focus on advancing the rights of women. Within this programme the State can recognise the historical and social context of entrenched gender inequality within South Africa and how it manifests in various forms of violence. Under this national programme the State must also incorporate specific strategies to improve social services so as to alleviate the gendered nature of socio-economic burdens.

---

[10] Article 25(2) of UDHR and Article 10(2) of ICESCR.
[11] General Comment 14, para 21.
[12] Concluding observations, paras 20 and 40.
[13] Paragraph 106(q), paragraph 24(b) of general recommendation 19, paragraph 15(b) of general recommendation 24 and paragraph 33 of the Recommendation on the Protection of Women against Violence.
[14] General Recommendation 24, para 24(m) and 16.
[15] General Recommendation 19, para 24(m).
[16] Bayefsky (2000) *Proceedings of the Annual Meeting (American Society of International Law)* 197.

Under this overarching programme, the Department of Health should also develop particular health care interventions for specific forms of GBV, such as domestic violence, rape and human trafficking. This should be complemented by the improvement of the existing infrastructure, such as improving the privacy of consulting rooms in public health care clinics, so as to facilitate increased protection for SGBV. In this regard, the State needs to expand current services that are offered to SGBV to include adequate psychological services, such as counselling.

In order for a national programme on GBV, and particular health care interventions for specific forms of GBV to be effectively implemented, health care providers will require adequate and specialised training to recognise and address GBV.[17] A transformative approach to GBV further requires recognition of the fact that in order to address the systemic nature of gender inequality, positive steps are necessarily required. The DVA and the SOA could therefore be amended to place positive duties on health care providers to provide quality and humane health care services to SGBV. Simultaneously, the State will need to develop an effective information system, while facilitating the participation of women and organisations focusing on women's rights, in drafting such a programme.

While the focus of this thesis is predominantly on the role of the courts, legislature and the executive in fostering substantive gender equality, the Commission for Gender Equality (hereafter "the Commission") does have particular responsibility in this regard. For example, the Constitution specifically mandates that the Commission must "promote respect for gender equality."[18] The Commission also has the specific power to monitor, investigate, research, educate, lobby, advise and report on issues concerning gender equality.[19] This places the Commission in the perfect position to gather gender-disaggregated data on women's particular health care needs and to lobby for women's health care needs to be recognised and addressed by the government.

Without adequate and explicit resource allocations, these obligations of the State towards SGBV will remain unfulfilled. In this regard, the State is required to take steps to make information on budgetary allocations to women's particular health care needs more transparent and accessible. Simultaneously the State will need to disseminate information on such health care programmes to the broader public of

[17] Guedes et al (2002) *Health and Human Rights* 189.
[18] Section 187 (1) of the Constitution of the Republic of South Africa, 1996 (hereafter "the Constitution").
[19] Section 187(2) of the Constitution.

South Africa as many women are not aware of their rights in this regard. Without access to information[20] and transparency[21] in budgeting and policy formulation, it will be difficult for organisations advocating for the rights of SGBV to hold the State to account for its obligations.

It is therefore submitted that a transformative approach to GBV requires that the State takes positive and innovative measures to foster substantive gender equality in South Africa. By facilitating access to health care services for SGBV, and by tailoring health care services to the specific needs of women so as to alleviate the socio-economic burdens experienced by women, existing law and policy can be transformed to be more responsive to the needs and circumstances of SGBV.

6 3 Concluding reflections

It is thus clear that despite the extreme levels of GBV in South Africa, we are not powerless to address it. In contrast, positive measures are specifically needed in order to shift South Africa's gendered political and social institutions and power relationships in a "democratic, participatory, and egalitarian direction." [22] By interpreting the socio-economic rights and the right to equality substantively and as mutually reinforcing, the law is therefore able to better respond to the intersecting axes of poverty and inequality. Furthermore, such an approach would highlight that women have specific health care needs based on both their biology and their gender.

Along with the courts, the legislature and the executive have a crucial role to fulfil in developing effective legislative and policy responses to the particular health care needs of SGBV. By facilitating the participation of abused women in shaping such health care responses to GBV, the law can effectively be used to articulate the experiences of abused women and to contribute to the social change that needs to occur. Furthermore, by grounding such services in the lived reality of abused

[20] The Promotion of Access to Information Act 2 of 2000 specifically gives effect to the constitutional right to have access to information (section 32 of the Constitution). The objects of the Act specifically include promoting transparency, accountability and effective governance of all public and private bodies(section 9(e)).

[21] In *Minister of Health and Others v Treatment Action Campaign and Others* 2002 (5) SA 703; 2002 (10) BCLR 1075, the Court held in para 123, that in order for a State programme to be effective, it must:

> "[B]e made known effectively to all concerned, down to the district nurse and patients. Indeed, for a public programme such as this to meet the constitutional requirement of reasonableness, its contents must be made known appropriately."

[22] K Klare "Legal Culture and Transformative Constitutionalism" (1998) 14 *SAJHR* 146 150.

women's lives, the law is able to provide remedies that are more responsive to the needs and experiences of SGBV.

The provision of quality health care services, such as effective counselling can further serve to prevent the escalation of domestic violence, while improving adherence to PEP. Simultaneously, by improving access to PEP, the State can effectively prevent the spread of HIV/AIDS. Sufficient psychological health care services can further empower abused women to effectively deal with the consequences of GBV within their lives.

The State is thus called upon to take the necessary steps to recognise all forms of GBV and to provide adequate and timely access to quality health care services for survivors of all forms of GBV. This is necessary, as unless all law-makers in South Africa take the intersection between the constitutional commitment to gender equality and the right of access to health care services seriously, the transformative promises of the Constitution will continue to have a "hollow ring"[23] for SGBV.

[23] *Soobramoney v Minister of Health, KwaZulu-Natal* 1998 1 SA 765 (CC); 1997 12 BCLR 1696 (CC) para 8.

Bibliography

Books

Cook R *Reproductive Health and Human Rights* (New York: Oxford University Press, 2003)

Goldblatt B & McLean K (eds) *Women's Social and Economic Rights* (Cape Town: Juta & Co, 2010)

Kristof N & Wudunn S *Half the Sky*: *How to Change the World* (Great Britain: Virago Press, 2010)

Liebenberg S *Socio-Economic Rights: Adjudication under a Transformative Constitution* (Cape Town: Juta & Co, 2010)

Meyersfeld B *Domestic Violence and International Law* (Oregon: Hart Publishing, 2010)

Sen A *Inequality Re-examined* (United States of America: Harvard University Press, 1992)

Vermeulen S *Stitched Up: Who fashions Women's Lives?* (Johannesburg: Jacana Media, 2004)

Yamin AE & Gloppen S (eds) *Litigating Health Rights: Can Courts Bring More Justice to Health?* (Massachusetts: Harvard University Press, 2011)

Chapters in books

Albertyn C, Artz L, Combrinck H , Mills S & Wolhuter H "Women's Freedom and Security of the Person" in Bonthuys E & Albertyn C (eds) *Gender, Law and Justice* (Cape Town: Juta & Co, 2007) 295-381

Albertyn C & Goldblatt B "Equality in the Final Constitution" in Woolman S, Roux T & Bishop M (eds) *Constitutional Law of South Africa* 2 ed (Original Service June 2008) (Cape Town: Juta & Co) Chapter 35-1

Artz L & Smyth D "Introduction: Should We Consent?" in Artz L & Smyth D (eds) *Should We Consent? Rape Law Reform in South Africa* (Cape Town: Juta & Co, 2008) 1-21

Bilchitz D "Khosa: Reasonableness and the Confusion of Scope and Content" in *Poverty and Fundamental Rights: The Justification and Enforcement of Socio-Economic Rights* (New York: Oxford University Press, 2007) 170–176

Bilchitz D "The Right to Health in the Final Constitution" in Woolman S, Roux T & Bishop M (eds) *Constitutional Law of South Africa* 2 ed (Original Service June 2008) (Cape Town: Juta & Co) 56A-2

Bourke-Martignoni J "The History and Development of the Due Diligence Standard in International Law" in Benninger-Budel C (ed) *Due Diligence and Its Application to Protect Women from Violence* (The Netherlands: Martinus Nijhoff Publishers, 2008) 47-62

Boyd S B "Introduction: Challenging the Public/Private Law Divide" in Boyd S B (ed) *Challenging the Public/Private Law Divide: Feminism, Law and Public Policy* (London: Toronto Press Incorporated, 1997) 1-36

Brand D "What are Socio-Economic Rights For?"' in Botha H, van der Walt A & van der Walt J (eds) *Rights and Democracy in a Transformative Constitution* (Stellenbosch: African Sun Media, 2003) 33-56

Chirwa DM & Khosa S "Towards Enhanced Citizenship and Poverty Eradication: A Critique of *Grootboom* From a Gender Perspective" in Gouws A (ed) *(Un)thinking Citizenship: Feminist Debates in Contemporary South Africa* (Lansdowne: University of Cape Town Press, 2005) 137-156

Chisala S "Rape and HIV/AIDS: Who's Protecting Whom?" in Artz L & Smythe D (eds) *Should We Consent?: Rape Law Reform in South Africa* (Cape Town: Juta & Co, 2008) 52-71

Clark B & Goldblatt B "Gender and Family Law" in Bonthuys E & Albertyn C (eds) *Gender, Law and Justice* (Cape Town: Juta & Co, 2007) 195-243

Currie I & De Waal J "Socio-Economic Rights: Housing, Health care, Food, Water and Social Security" in Currie I & De Waal J *The Bill of Rights Handbook* 5ed (Cape Town: Juta & Co, 2008) 566-598

Dugard J "Sources of International Law" in Dugard J *International Law: A South African perspective* 3 ed (Cape Town: Juta & Co, 2007) 27-46

Du Plessis L "Beyond Parochialism? Transnational Contextualisation in Constitutional Interpretation in South Africa: With Particular Reference to Jurisprudence of the Constitutional Court" in Faure M (ed) *Globalisation and Private Law: the Way Forward* (United Kingdom: Edward Elgar Publishing Limited, 2010) 145-182

du Toit L "A Phenomenology of Rape: Forging a New Vocabulary for Action" in Gouws A (ed) *(Un)thinking Citizenship: Feminist Debates in Contemporary South Africa* (Lansdowne: University of Cape Town Press, 2005) 253-274

Fraser N "From Redistribution to Recognition: Dilemmas of Justice in a "Post-socialist" Age?" in *Justice Interruptus: Critical Reflections on the Post-Socialist Condition* (New York: Routledge, 1997) 11-66

Fredman S "Rights and Remedies: The Limits of the law" in S Fredman *Discrimination Law* 2 ed (New York: Oxford University Press, 2011) 278-317

Goldblatt B "Citizenship and the Right to Child Care" in Gouws A (ed) *(Un)thinking Citizenship: Feminist Debates in Contemporary South Africa* (Lansdowne: University of Cape Town Press, 2005) 117-136

Goldblatt B "Evaluating the Gender Content of Reparations: Lessons from South Africa" in Rubio-Marin, R (ed) *What Happened to the Women? Gender and Reparations for Human Rights Violations* (New York: Social Science Research Council, 2006) 48-91

KirombaTwinomugisha B "Beyond Juridical Approaches: What Role can the Gender Perspective Play in Interrogating the Right to Health in Africa" in Viljoen F (ed) *Beyond the Law: Multidisciplinary Perspectives on Human Rights* (Pretoria: Pretoria University Law Press, 2012) 41-66

Mushariwa M "The Right to Reproductive Health and Access to Health Care Services within the Prevention of Mother-to-child Transmission Programme: The Reality on the Ground in the Face of HIV/AIDS" in Goldblatt B & McLean K (eds) *Women's Social and Economic Rights* (Cape Town: Juta & Co, 2011) 183-205

Nedelsky J "Violence against Women: Challenges to the Liberal State and Relational Feminism" in Shapiro I & Hardin R (eds) *Political Order* (New York: University press, 1998) 454-497

Nedelsky J "Violence against Women: Challenges to the Liberal State and Feminism" in Nedelsky J *Law's Relations: A Relational Theory of Self, Autonomy, and Law* (New York: Oxford University Press, 2011) 200-230

Ngwena C & Cook R "Rights Concerning Health" in Brand D and Heyns C (eds) *Socio Economic Rights in South Africa* (Pretoria: Pretoria University Law Press, 2005) 107-152

Nussbaum M "Introduction: Feminism and International Law" in *Women and Human Development: The Capabilities Approach* (United States of America: Cambridge University Press, 2000) 1-33

Plata M I “Reproductive Rights as Human Rights” in Cook R (ed) *Human Rights of Women: National and International Perspectives* (United States of America: University of Pennsylvania Press, 1994) 515-531

Roehrs S “Half-hearted HIV Related Services for Victims” in Artz L & Smythe D (eds) *Should We Consent?: Rape Law reform in South Africa* (Cape Town: Juta & Co, 2008) 175-197

Shue H “Correlative Duties” in Shue H *Basic Rights: Subsistence, Affluence, and U.S. Foreign Policy* 2nd ed (New Jersey: Princeton University Press, 1996) 35-64

Journal articles

Abrahams N & Jewkes R "Barriers to Post Exposure Prophylaxis (PEP) Completion after Rape: A South African Qualitative Study" (2010) 12 *Culture, Health & Sexuality* 471-484

Albertyn C & Goldblatt B "Facing the Challenge of Transformation: Difficulties in the Development of an Indigenous Jurisprudence of Equality" (1998) 14 *South African Journal on Human Rights* 248-276

Albertyn C "Contesting Democracy: HIV/AIDS and the Achievement of Gender Equality in South Africa" (2003) 29 *Feminist Studies* 595-615

Albertyn C "Substantive Equality and Transformation in South Africa" (2007) 23 *South African Journal on Human Rights* 253- 276

Albertyn C, Fredman S, & Fudge J "Introduction: Substantive Equality, Social Rights and Women: A Comparative Perspective" (2007) 23 *South African Journal on Human Rights* 209-213

Albertyn C "Gendered Transformation in South African Jurisprudence: Poor Women and the Constitutional Court" (2012) 22 *Stellenbosch Law Review* 591-613

Amollo R "Advancing Women's Access to Health Services in South Africa: Legal and Policy Responses to HIV/AIDS" (2009) 10 *Economic and Social Rights Review* 3-7

Amollo R "The National Health Insurance Policy: What's in it for Women's Health?" (2012) 92 *Agenda* 111-125

Artz L "Policing the Domestic Violence Act: Teething Troubles or System Failure" (2001) 47 *Agenda* 4-13

Artz L & Smythe D "Bridges and Barriers: A Five Year Retrospective on the Domestic Violence Act" (2005) *Acta Juridica* 200-226

Artz L & Smythe D "Feminism vs the State? A Decade of Sexual Offences Reform in South Africa" (2007) 74 *Agenda* 6-19

Bayefsky A "The CEDAW Convention: It's Contribution Today" (2000) 94 *Proceedings of the Annual Meeting (American Society of International Law)* 197-203

Bentley K "Women's Human Rights and the Feminization of Poverty in South Africa" (2004) 31 *Review of African Political Economy* 247-261

Bettinger-Lopez C "*Jessic Gonzales v United States:* An Emerging Model for Domestic Violence & Human Rights Advocacy in the United States (2008) 21 *Harvard Human Rights* 183 -195

Bilchitz D "Giving Socio-Economic Rights Teeth: The Minimum Core and its Importance" (2002) 119 *South African Law Journal* 484-501

Bonthuys E "The Personal and the Judicial: Sex, Gender and Impartiality" (2008) 24 *South African Journal on Human Rights* 239-262

Bonthuys E "Institutional Openness and Resistance to Feminist Arguments: The Example of the South African Constitutional Court" (2008) 20 *Canadian Journal of Women and the Law* 1-36

Budlender D "The Political Economy of Women's Budgets in the South" (2000) 28 *World Development* 1365-1378

Budlender D "Women and Poverty" (2005) 64 *Agenda* 30-36

Brodsky G & Day S "Denial of the Means of Subsistence as an Equality Violation" (2005) *Acta Juridica* 149-170

Campbell C "Learning to Kill? Masculinity, the Family and Violence in Natal" (1992) 18 *Journal of South African Studies* 614 -628

Chant S "Re-thinking the Feminisation of Poverty in regard to Aggregate Gender Indices (2006) 7 *Journal of Human Development* 201-220

Charlesworth H, Chinkin C & Wright S "Feminist Approaches to International Law" (1991) 85 *American Journal of International Law* 613-645

Charlesworth H "Feminist Methods in International Law" (1999) 93 *American Journal of International Law* 379 -394

Chenwi L & McLean K "A woman's Home is her Castle? - Poor Women and Housing Inadequacy in South Africa" (2009) 25 *South African Journal on Human Rights* 517-545

Chescheir N "Violence against Women: Responses from Clinicians" (1996) 27 *Annals of Emergency Medicine* 765-768

Chirwa DM "'Non-state Actors' Responsibility for Socio-Economic Rights: The Nature of Their Obligations under the South African Constitution" (2002) 3 *Economic and Social Rights Review* 1-7

Chirwa DM "Implications for the Obligations of State and Non-State Actors in Ensuring Access to Essential Medicine" (2003) 19 *South African Journal on Human Rights* 541-566

Chopra M, Daviaud E, Pattinson R, Fonn S & Lawn J E "Saving the Lives of South Africa's Mothers, Babies, and Children: Can the Health System Deliver?" (2009) 374 *The Lancet* 835 –846

Christofides N, Jewkes R, Webster N, Penn-Kekana L, Abrahams N & Martin LJ "Other Patients are Really in Need of Medical Attention'- The Quality of Health Services for Rape Survivors in South Africa" (2005) 83 *Bulletin of the World Health Organisation* 495 -502

Christofides J, Muirhead D, Jewkes R, Penn-Kekana L, Conco DN "Women's Experiences of, and Preferences for, Services after Rape in South Africa: Interview Study" (2006) 332 *British Medical Journal* 209-212

Cristofides N & Jewkes R "Acceptability of Universal Screening for Intimate Partner Violence in Voluntary HIV Testing and Counseling Services in South Africa and Service Implications" (2010) 22 *Aids Care* 279-285

Coker A, Hopenhayn C, DeSimone C, Bush H & Crofford L "Violence against Women Raises Risk of Cervical Cancer" (2009) 18 *Journal of Women's Health* 1179-1185

Colombini M, Mayhew S & Watts C World Health Organisation "Health-Sector Responses to Intimate Partner Violence in Low- and Middle-Income Settings: A Review of Current Models, Challenges and Opportunities" (2008) 86 *Bulletin of the World Health Organisation* 577-656

Combrinck H "Positive State Duties to Protect Women from Violence: Recent South African Developments" (1998) 20 *Human Rights Quarterly* 666-691

Combrinck H "The Dark Side of the Rainbow: Violence against Women in South Africa after Ten Years of Democracy" (2005) *Acta Juridica: Advancing Women's Rights* 171-199

Cook R J "International Human Rights and Women's Reproductive Health" (1993) 24 *Studies in Family Planning* 73- 86

Cooper D, Morroni C, Omer P, Moodley J, Harries J, Cullingworth L & Hoffmanb M "Ten years of democracy in South Africa: Documenting Transformation in Reproductive Health Policy and Status" (2004) 24 *Reproductive Health Matters* 70-85

Coovadia H, Jewkes R, Barron P, Sanders D & McIntyre D "The Health and Health System of South Africa 1: Historical Roots of Current Public Health Care Challenges" (2009) 374 *The Lancet* 817-834

Copelon R "Recognising the Egregious in the Everyday: Domestic Violence as Torture" (1994) 25 *Columbia Human Rights Law Review* 291-353

Currin E & Bonthuys E "Customary Law and Domestic Violence in Rural South African Communities" (2005) 21 *South African Journal on Human Rights* 607- 636

De Vos P "*Grootboom,* the Right of Access to Housing and Substantive Equality as Contextual Fairness" (2001) 17 *South African Journal on Human Rights* 258-276

De Wet E "The "Friendly but Cautious" Reception of International Law in the Jurisprudence of the South African Constitutional Court: Some Critical Remarks" (2005) 28 *Fordham International Law Journal* 1529-1535.

Doolan C "Missing Piece in the Puzzle: The Health Sector's Role in Implementing the Domestic Violence Act" (2005) 12 *South Africa Crime Quarterly* 9-12

Dugard J "The Role of International Law in Interpreting the Bill of Rights" (1994) 10 *South African Journal on Human Rights* 208-215

Dugard J & Mohlakoana N "More Work for Women: A Rights -Based Analysis of Women's Access to Basic Services in South Africa" (2009) 25 *South African Journal on Human Rights* 546-572

Durojaye E "Advancing Gender Equity in Access to HIV Treatment through the Protocol on the Rights of Women in Africa" (2006) 6 *African Human Rights Law Journal* 188-207

Merry SE "Rights Talk and the Experience of Law: Implementing Women's Human Rights to Protection from Violence" (2003) 25 *Human Rights Quarterly* 343-381

Farley M, Baral I, Kiremire M, Sezgin U, "Prostitution in Five Countries: Violence and Posttraumatic Stress Disorder" (1998) 8 *Feminism & Psychology* 405-426

Ferris L "Intimate Partner Violence: Doctors Should Offer Referral to Existing Interventions, While Better Evidence is Awaited" (2004) 328 *British Medical Journal* 595-596

Fraser N "Talking about Needs: Interpretive Contests as Political Conflicts in Welfare-State Societies" (1989) 99 *Ethics* 291-313

Fredman S "Providing Equality: Substantive Equality and the Positive Duty to Provide" (2005) 21 *South African Journal on Human Rights* 163-190

Fredman S "Redistribution and Recognition: Reconciling Inequalities" (2007) 23 *South African Journal on Human Rights* 214-234

Fredman S "Engendering Socio-Economic Rights" (2009) 25 *South African Journal on Human Rights* 410- 441

Gerntholtz L & Richter M "Young Women's Access to Reproductive Health Care Services in the Context of HIV" (2002) 53 *Agenda* 99-105

Hessbrugge J A "The Historical Development of the Doctrines of Attribution and Due Diligence in International Law" (2003) 36 *New York University Journal of International Law and Politics* 265 -307

Goldblatt B "Regulating Domestic Partnerships-*A Necessary Step in the Development of South African Family Law*" (2003) 120 *South African Law Journal* 610- 629

Jewkes R "Intimate Partner Violence, Causes and Prevention" (2002) 359 *The Lancet* 1423- 1429

Jewkes R "Vezimfilho: A Model for Health Sector Response to Gender Violence in South Africa" (2002) 78 *International Journal of Gynecology and Obstetrics* 51 -56.

Jewkes R, Levin J & Penn-Kekana L "Gender Inequalities, Intimate Partner Violence and HIV Preventive Practices: Findings of a South African Cross-Sectional Study," (2003) 56 *Social Science & Medicine* 125–134

Jewkes R, Dunkle K, Nduna M & Shai N "Intimate Partner Violence, Relationship Gender Power Inequity, and Incidence of HIV Infection in Young Women in South Africa: A Cohort Study." (2010) 367 *The Lancet* 41–48

Jewkes R & Morrel R "Sexuality and the Limits of Agency among South African Teenage women: Theorising Femininities and their Connections to HIV Risk Practises" (2012) 74 *Social Science & Medicine* 1729-1737

Kaminer D, Grimsrud A, Myer L, Stein DJ & Williams DR "Risk for Post-traumatic Stress Disorder Associated with Different Forms of Interpersonal Violence in South Africa" (2008) 67 *Social Science & Medicine* 1589-1595

Kapp C "New Hope for Health in South Africa" (2008) 372 *The Lancet* 1207-1208

Kehler J "Women and Poverty: The South African Experience" (2001) 3 *Journal of International Women's Studies* 1-13

Klare K E "Legal Culture and Transformative Constitutionalism" (1998) 14 *South African Journal on Human Rights* 146-188

Langa P "Transformative Constitutionalism" (2006) 17 *Stellenbosch Law Review* 351-360

Liebenberg S "Social Citizenship — a Precondition for Meaningful Democracy" (1999) 40 *Agenda* 59-65

Liebenberg, S & O'Sullivan M "South Africa's New Equality Legislation: A Tool for Advancing Women's Socio-Economic Equality?" (2001) 21 *Acta Juridica* 70-103

Liebenberg S "Needs, Rights and Transformation: Adjudicating Social Rights" (2005) 8 *Centre for Human Rights and Global Justice* 1-33

Liebenberg S & Goldblatt B "The Interrelationship between Equality and Socio-Economic Rights under South Africa's Transformative Constitution" (2007) 23 *South African Journal on Human Rights* 335-361

McIntyre D & Gilson L "Putting Equity in Health back onto the Social Policy Agenda: Experience from South Africa" 54 *Social Science & Medicine* (2002) 1637-1656

Mercy J, Butchart A, Rosenberg M, Dahlberg L & Harvey A "Preventing Violence in Developing Countries: A Framework for Action" (2008) 15 *International Journal of Injury Control and Safety Promotion* 197-208

Meyersfeld B "Domestic Violence, Health, and International Law" (2008) 22 *Emory International Law Review* 61-112

Morrison A, Ellsberg M & Bott S "Addressing Gender-Based Violence: A Critical Review of Interventions" (2007) 22 *World Bank Research Observer* 25- 51

Mthembu S "Cervical Cancer and Women Living with HIV in South Africa: Failure of AIDS Treatment Policy or Gendered Exclusions in Health Care?" 92 *Agenda* 35-43

Mureinik E "A Bridge to Where? Introducing the Interim Bill of Rights" (1994) 10 *South African Journal on Human Rights* 31-48

Muthren B "Strategic Interventions; Intersections between Gender-based Violence and HIV/AIDS" (2004) 59 *Agenda* 93- 99

Nedelsky J "Embodied Diversity and Challenges to Law" (1997) 42 *McGill Law Journal* 91-117

Nussbaum M "Capabilities as Fundamental Entitlements: Sen and Social Justice" (2003) 9 *Feminist Economics* 33-59

Nussbaum M "Women's Bodies: Violence, Security Capabilities" (2005) 6 *Journal of Human Development* 167-183

O'Hare U "Realising Human Rights for Women" (1999) 21 *Human Rights Quarterly* 364-402

Olsen F E "The Myth of State Intervention in the Family" (1985) 18 *Michigan Journal of Law Reform* 835-864

Paulus E & Simpson A "Will Health Reform Proposals Realise the Right to Health of Women and Girl Children in Particular? A Reflection" (2011) 12 *Economic and Social Rights Review* 9-12

Petersen I "Comprehensive Integrated Primary Mental Health Care for South Africa: Pipedream or Possibility?" (2000) 51 *Social Science & Medicine* 321-334

Pieterse M "Coming to Terms with Judicial Enforcement of Socio-Economic Rights" (2004) 20 *South African Journal on Human Rights* 383-411

Pieterse M "Resuscitating Socio-Economic Rights: Constitutional Entitlements to Health Care Services" (2006) 22 *South African Journal on Human Rights* 473-502

Pieterse M "Indirect Horizontal Application of the Right to have Access to Health Care Services" (2007) 23 *South African Journal on Human Rights* 157-179

Pieterse M "Health Care Rights, Resources and Rationing" (2007) 124 *South African Law Journal* 514-536

Pieterse M "The Interdependence of Rights to Health and Autonomy in South Africa" (2008) 125 *South African Law Journal* 553-572

Pieterse M "Relational Socio-Economic Rights" (2009) 25 *South African Journal on Human Rights* 198-217

Pieterse M "Legislative and Executive Translation of the Right to Have Access to Health Care Services" (2010) 14 *Law, Democracy & Development* 1-25

Pollack M A & Hafner-Burton E "Mainstreaming Gender in the European Union" (2000) 7 *Journal of European Public Policy* 432-456

Randall T "Domestic Violence Interventions Call for More than Treating Injuries" (1990) 264 *Journal of the American Medical Association* 939- 940

Romany C "Women as Aliens: A Feminist Critique of the Public/Private Distinction in International Human Rights Law" (1993) 6 *Harvard Human Rights Journa*l 87-113

Romany C "Black Women and Gender Equality in a New South Africa: Human Rights Law and the Intersection of Race and Gender" (1996) 21 *Brooklyn Journal of International Law* 857-898

Sainsbury D & Bergqvist C "The Promise and Pitfalls of Gender Mainstreaming: The Swedish Case" (2009)11 *International Feminist Journal of Politics* 216 -234

Scott C "The Interdependence and Permeability of Human Rights Norms: Towards A Partial Fusion of the International Covenants on Human Rights" (1989) 27 *Osgoode Hall Law Journal* 769-878

Seedat M, Van Niekerk A, Jewkes R, Suffla S & Ratele K "Violence and Injuries in South Africa: Prioritising an Agenda for Prevention" (2009) 374 *The Lancet* 1011-1022

Sen A "Why Health Equity?" (2002) 11 *Health Economics* 659-662

Sen A "Human Rights and Capabilities" (2005) 6 *Journal of Human Development* 151-166

Van Leeuwen F & Amollo R "A Human Rights Based Approach to Improving Maternal Health: Possibilities for Realising Millennium Development Goal 5" (2009) 10 *Economic and Social Rights Review* 21- 24

Vetten L "Show Me the Money": A Review of Budgets Allocated Towards the Implementation of the Domestic Violence Act (no. 116 of 1998)" (2005) 32 *Politikon* 277-295

Vetten L & Haffejee S "Supporting Rape Survivors in Adhering to Post-Exposure Prophylaxis (PEP) to Prevent HIV Infection: The Importance of Psychosocial Counselling and Support" (2008) 23 *Southern African Journal of HIV Medicine* 1-5

Vetten L & Jacobs T "Towards Developing and Strengthening a Comprehensive Response to the Health Care Needs of Rape Survivors" (2008) 1 *Policy Brief* 1-6

Welch CE "Human Rights and African Women: A Comparison of Protection under Two Major Treaties" (1993) 15 *Human Rights Quarterly* 549-574

Williams L "Issues and Challenges in Addressing Poverty and Legal Rights: A Comparative United States/South Africa Analysis" (2005) 21 *South African Journal on Human Rights* 436-472

Table of cases

African Commission on Human and People's Rights

Purohit and Moore v The Gambia Communication No.241/2001

Social and Economic Rights Action Center & the Center for Economic and Social Rights v. Nigeria Communication No. 155/96

European Committee on Social Rights

European Roma Rights Centre v Bulgaria Collective Complaint 46/2007

European Court of Human Rights

Opuz v Turkey, (2009) 2 ECHR Application number 33401/02

Inter-American Commission on Human Rights

Maria Da Penha Maia Fernandes v Brazil Report No 54/01 Case 12.051

Jessica Lenahan (Gonzales) v United States Report No. 80/11 Case 12.626

International Criminal Tribunal for Rwanda

Prosecutor v Akayesu Case No. ICTR-96-4-T

South Africa

Bhe v Magistrate, Khayelitsha; *Shibi v Sithole*; *South African Human Rights Commission v President of the Republic of South Africa* 2005 1 SA 580 (CC); 2005 1 BCLR 1 (CC).

Brink v Kitshoff NO 1996 4 SA 197 (CC); 1996 6 BCLR 752 (CC)

Carmichelle v Minister of Safety and Security and Another 2001 4 SA 938 (CC); 2001 10 BCLR 995 (CC)

Director of Public Prosecutions, Western Cape v Prins [2012] ZAWCHC 42 (11 May 2012)

Director of Public Prosecutions, Western Cape v Prins (Minister of Justice and Constitutional Development & two amici curiae intervening) (369/12) [2012] 106 ZASCA; 2012 (2) SACR 183 (SCA)

F v Minister of Safety and Security 2012 1 SA 536 (CC); 2012 3 BCLR 244 (CC)

Governing Body of the Juma Musjid Primary School & Others v Essay N.O. and Others (CCT 29/10) [2011] ZACC 13; 2011 8 BCLR 761 (CC) (11 April 2011)

Government of the Republic of South Africa v Grootboom 2001 1 SA 46 (CC); 2000 11 BCLR 1169 (CC)

Harksen v Lane NO and Others 1997 11 BCLR 1489; 1998 1 SA 300

Hoffman v South African Airways 2001 1 SA 1; 2000 11 BCLR 1235

Khosa v Minister of Social Development; Mahlaule v Minister of Social Development 2004 6 SA 505 (CC); 2004 6 BCLR 569 (CC)

Law Society of South Africa and Others v Minister for Transport and Another 2011 1 SA 400 (CC)

Mazibuko v City of Johannesburg (Centre on Housing Rights and Evictions as Amicus Curiae) [2008] 4 All SA 471 (W)

Mazibuko and Others v The City of Johannesburg and Others 2010 4 SA 1(CC); 2010 (3) BCLR 239 (CC)

Minister of Finance v Van Heerden 2004 (6) SA 121 (CC); 2004 (11) BCLR 1125 (CC)

Minister of Health and Others v Treatment Action Campaign (No 2) 2002 (5) SA 721 (CC), 2002 (10) BCLR 1033 (CC)

Minister of Home Affairs v Fourie (Doctors for Life International and Others, Amici Curiae); Lesbian and Gay Equality Project and Others v Minister of Home Affairs 2006 (1) SA 524 (CC); 2006 3 BCLR 355 (CC)

Minister of Safety and Security v Van Duivenboden 2002 6 SA 431 (SCA)

National Coalition for Gay and Lesbian Equality v Minister of Justice (1999) 1 SA 6 (CC); 1999 3 BCLR 280 (CC)

Occupiers of 51 Olivia Road, Berea Township and 197 Main Street Johannesburg v City of Johannesburg and Others 2008 3 SA 208 (CC); 2008 5 BCLR 475 (CC)

Omar v Government of the Republic of South Africa and Others (Commission for Gender Equality, Amicus Curiae) 2006 2 SA 289 (CC); 2006 2 BCLR 253 (CC)

Port Elizabeth Municipality v Various Occupiers 2005 1 SA 217 (CC); 2004 12 BCLR 1268 (CC)

President of the Republic of South Africa v Hugo 1997 4 SA 1 (CC); 1997 6 BCLR 708

K v Minister of Safety and Security 2005 6 SA 419 (CC); 2005 9 BCLR 835 (CC)

Masiya v Director of Public Prosecutions Pretoria (The State) and another 2007 5 SA 30 (CC); 2007 8 BCLR 827

S v Baloyi 2000 1 BCLR 86 (CC); 2000 1 SACR 81 (CC)

S v Jordan (Sex Workers Education & Advocacy Task Force as Amicus Curiae) 2002 6 SA 642 (CC); 2002 11 BCLR 1117 (CC)

S v Chapman 1997 3 SA 341 (SCA)

S v Engelbrecht 2005 2 SACR 41 (W)

Soobramoney v Minister of Health, KwaZulu-Natal 1998 1 SA 765 (CC), 1997 12 BCLR 1696 (CC)

S v Makwanyane and Another 1995 2 SACR 1; 1995 6 BCLR 665; [1995] ZACC

S v M (Centre for Child Law as Amicus Curiae) [2007] ZACC 18; 2008 (3) SA 232 (CC)

S v The State and the Centre for Child Law CCT 63/10 [2011] ZACC 7

S v Zuma 2006 2 SACR (W*)*

Volks NO v Robinson 2005 5 BCLR 446 (CC)

Western Cape Forum for intellectual Disability v Government of the Republic of South Africa and Another 2011 (5) SA 87 (WCC)) [2010] ZAWCHC 544; 18678/2007

Supreme Court of Canda

Eldridge v Attorney General of British Columbia (1997) 151 DLR (4th) 577 (SCC)

Supreme Court of the United Kingdom

Yemshaw v London Borough of Hounslow [2011] UKSC 3

United Nations Committee on the Elimination of Discrimination against Women

Alyne v Brazil (Communication 17/2008) Reference No: CEDAW/C/49/D/17/2008

Goekce (deceased) v Austria (Communication No. 6/2005) Reference No: CEDAW/C/39/D/5/2005

Ms A. S. v Hungary (Communication number 4/2004) Reference No: CEDAW/C/36/D/4/2004

South African law

South African Constitution

Constitution of the Republic of South Africa, 1996

Index of South African Legislation

Choice on Termination of Pregnancy Act 92 of 1996

Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007

Domestic Violence Act 116 of 1998

Maintenance of Surviving Spouses Act 27 of 1990

Medical Schemes Act 131 of 1998

National Health Act 61 of 2003

Prevention of Family Violence Act 133 of 1993

Promotion of Access to Information Act 2 of 2000

Promotion of Equality and the Prevention of Unfair Discrimination Act 4 of 2000

South African Bills:

Domestic Partnerships Bill of 2008

Prevention and Combating of Trafficking in Persons Bill 7 of 2010

Protection from harassment Bill 1 of 2010

International law treaties, instruments and reports

African Union

African Charter on Human and Peoples' Rights (1981) OAU Doc CAB/LEG/67/rev.5

African Commission on Human and People's Rights "Principles and Guidelines on the Implementation of Economic, Social and Cultural Rights in the African Charter on Human and Peoples' Rights"

Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (2000) CAB/LEG/66.6

European Council

Council of Europe Committee of Ministers "The Protection of Women against Violence" Recommendation (2002)

Council of Europe "Convention on Preventing and Combating Violence against Women and Domestic Violence" (2011) CETS No 210

European Convention for the Protection of Human Rights and Fundamental Freedoms 213 UNTS 222

Parliamentary Assembly of the Council of Europe, "Recommendation 1582 (2002) Domestic Violence against Women' (27 September 2002)

Organisation of American States

Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights OAS Treaty Series No. 69

American Convention on Human Rights O.A.S.Treaty Series No. 36, 1144 UNTS 123

American Declaration of the Rights and Duties of Man OAS doc. OEA/Ser.L/V/II.65,Doc 6

Inter-American Convention on the Prevention, Punishment and Eradication of Violence against Women (1994) 1867 UNTS 154

United Nations

Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (1984) UN Doc A/39/51

Convention on the Elimination of All Forms of Discrimination against Women (1977) UN Doc A/34/46

Convention on the Rights of the Child (1989) 1577 UNTS 3

International Covenant on Economic, Social, and Cultural Rights (1966) UN Doc A/6316

International Federation for Human Rights, *Montreal Principles on Women's Economic, Social and Cultural Rights* (2002)

Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women (2000) UN Doc A/54/49

Standard Minimum Rules for the Treatment of Prisoners (1955), U.N. Doc. A/CONF/611

United Nations Convention against Transnational Organized Crime (2001) UN Doc Convention on the Elimination of all Forms of Racial Discrimination (1965) 660 UNTS 195 A/45/49

United Nations Committee on Economic, Social and Cultural Rights in General Comment No 3 *The nature of State parties' obligations*, (1990) (article 2 para 1 of the Covenant) UN Doc 1990/12/14

United Nations Committee on Economic, Social and Cultural Rights, General Comment No 13 *The Right to Education,* (1999) (article 13 of the Covenant) UN Doc E/C.12/1999/10

United Nations Committee on Economic, Social and Cultural Rights, General Comment No 14 *The right to the highest attainable standard of health*, (2000) (article 12 of the Covenant) UN Doc E/C.12/2000/4

United Nations Committee on Economic, Social and Cultural Rights, General Comment No 16 *The equal right of men and women to the enjoyment of all economic, social and cultural rights* (2005) (article 3 of the Covenant) UN Doc E/C.12/2005/3

United Nations Committee on Economic, Social and Cultural Rights, General Comment No 20 *Non-discrimination in economic, social and cultural rights* (2009) (article 2, para 2, of the Covenant) UN Doc E/C.12/GC/20

United Nations Committee on the Elimination of Discrimination against Women "Concluding observations of the Committee on the Elimination of Discrimination against Women to South Africa" (2011) UN Doc CEDAW/C/ZAF/CO/4

United Nations Committee on the Elimination of Discrimination against Women, General Recommendation No 12 *Violence against Women* (1989) (article 1 of the Convention) U.N. Doc. A/44/38

United Nations Committee on the Convention on the Elimination of Discrimination Against Women, General Recommendation No 19 *Violence Against Women* (1992) (article 9 of the Convention) UN Doc A/47/38

United Nations Committee on the Elimination of Discrimination against Women, General Recommendation No 24 *Women and Health* (1999) (article 12 of the Convention), UN Doc A/ 54/38/Rev.1

United Nations Committee on the Elimination of Discrimination against Women General Recommendation No 25: *On Temporary Special Measures* (2000) (article 4, paragraph 1 of the Convention)

United Nations General Assembly Declaration on the Elimination of Violence Against Women (1993) UN Doc A/RES/48/104

United Nations Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children (2001) UN Doc A/.

United Nations Statute of the International Court of Justice (1946)

International research reports

Ettiene G, Krug L, Dahlberg J, Anthony AM, Zwi B & Lozano R (eds) (World Health Organisation) *World Report on Violence and Health* 2002 Geneva: World Health Organisation) 1-22 13<http://whqlibdoc.who.int/publications/2002/9241545615_chap4_eng.pdf> (accessed 13-02-2011)

Ertürk Y, United Nations Special Rapporteur on Violence against Women "The Due Diligence Standard as a Tool for the Elimination of Violence against Women: Report of the Special Rapporteur on Violence against Women, Its Causes and Consequences" (2006) UN E/CN.4/2006/61

Human Rights Watch "Maternal Mortality in South Africa and Eastern Cape" in *Stop Making Excuses: Accountability for Maternal Health Care in South Africa* (2011) 1 19 <http://www.hrw.org/node/100757> (accessed 14-07-2011)

Sen G, Östlin P & George A "Unequal, Unfair, Ineffective and Inefficient Gender Inequity in Health: Why it Exists and How We Can Change It" (2007) 1 145 <http://www.who.int/social_determinants/resources/csdh_media/wgekn_final_report_07.pdf> (accessed 12-06-2012)

United States Agency for International Development "Addressing Gender-based Violence through USAID'S Health Program: A Guide for Health Sector Programme Officers" (2006) 1-49 < http://www.prb.org/pdf05/gbvreportfinal.pdf> (accessed 12-04-2012)

United Nations Agency International Development South Africa "Final Report on the Compliance Assessment of the Thuthuzela Care Centres with National Department of Health Guidelines for Managing HIV in the Context of Sexual Assault" (2007) 1-80 <http://pdf.usaid.gov/pdf_docs/PNADT749.pdf> (accessed 12-03-2011)

United Nations Population Fund *State of the World Population 2005: The Promise of Equality: Gender Equity, Reproductive Health and the Millennium Development Goals* (2005) i- 119 <http://www.unfpa.org/swp/2005/index.htm> (accessed 24-02-2011)

United States Department of State “Trafficking in Persons Report” (2005) 1 -258 <http://www.state.gov/documents/organization/47255.pdf> (accessed 25-03-2011)

Velzeboer M, Ellsberg M, Arcas CC & García-Moreno C (Pan American Health Organisation) “Violence against Women: The Health Sector Responds” (2003) 1-39 <http://www.path.org/publications/files/GVR_vaw_health_sector_fm-1-3.pdf> (accessed 04-07-2011)

World Bank: A Morrison, S Bott & M Ellsberg “Addressing Gender-Based Violence in the Latin American and Caribbean Region: A Critical Review of Interventions” (2004) World Bank Policy Research Working Paper 3438 1-77 <http://siteresources.worldbank.org/INTLACREGTOPPOVANA/Resources/Morrison_Ellsbergh_Bott.pdf > (accessed 09-04-2012)

World Health Organisation *Constitution of the World Health Organisation*, adopted by the International Health Conference on 22 July 1946, opened for signature on 22 July 1946 and entered into force on 7 April 1948 <http://www.who.int/governance/eb/who_constitution_en.pdf> (accessed 12-04-2012)

World Health Organization: Geneva “Violence against women Fact sheet No.239” (2009) 1 <http://www.who.int/mediacentre/factsheets/fs239/en/> (accessed 10-11-2010)

World Health Organisation &International Labour Organisation “Definitions” in *Post-exposure prophylaxis to prevent HIV infection: joint WHO/ILO guidelines on post-exposure prophylaxis* (2007 Geneva: World Health Organisation) 1-104 <http://whqlibdoc.who.int/publications/2007/9789241596374_eng.pdf> (accessed 14-03-2011)

South African government policy documents and reports

Department of Health "White Paper for the Transformation of the Health System in South Africa" 1997 <http://www.info.gov.za/whitepapers/1997/health.htm> (accessed 12-03-2012)

Department of Health "The Primary Health Care Package for South Africa – A Set of Norms and Standards" in Department of Health Policy Documents (2000) 1-87 <http://www.doh.gov.za/docs/index.html> (accessed 01-03-2011)

Department of Health "The National Guidelines on Prevention, Early Detection / Identification and Intervention of Physical Abuse of Older Persons at Primary Level" (2000) <http://webapps01.un.org/vawdatabase/uploads/National%20guideline%20on%20prevention%20of%20physical%20abuse%20of%20elderly%20persons.pdf> (accessed 12-11-2011)

Department of Health "National Management Guidelines for Sexual Assault Care" (2003) <http://www.tlac.org.za/wp-content/uploads/2012/01/Sexual-Assault-Guidelines-2003.pdf> (accessed 29-04-2011)

Department of Health "National Sexual Assault Policy" (2005) 1-28 <http://webapps01.un.org/vawdatabase/uploads/National%20Sexual%20Assault%20Policy%20-%202005.pdf> (accessed 15-04-2011)

Department of Health "A Policy on Quality in Health Care for South Africa" National Department of Health South Africa (2007) 1-28 <http://www.doh.gov.za/docs/policy/quality_healthcare.pdf > (accessed 20-02-2011)

Department of Health "HIV & AIDS and STI National Strategic Plan 2007 – 2011" National Department of Health South Africa (2007) 1-142 < http://www.info.gov.za/otherdocs/2007/aidsplan2007/khomanani_HIV_plan.pdf> (accessed 12-01-2011)

Department of Health "National Policy Guidelines for Victim Empowerment" (2009) 1-40 <http://www.pmg.org.za/files/docs/090916victim.pdf> (accessed 15-02-2011)

Department of Health "Strategic Plan for 2010/11-2012/13" (2010) <http://www.doh.gov.za/docs/stratdocs/2010/part1.pdf> (accessed 12-05-2011)

Department of Health of South Africa "The National Strategic Plan for HIV and AIDS, Sexually Transmitted Infections and Tubercolosis, 2012 - 2016" (2011) <http://www.sanac.org.za/files/uploaded/519_NSP%20Draft%20Zero%20110808%20pdf%20%20final.pdf> (accessed 12-05-2011)

Department of Health "National Health Insurance in South Africa Policy Paper" (2011) 9 <http://www.info.gov.za/view/DownloadFileAction?id=148470> (accessed 11-08-2011)

Department of Health "Annual Performance Plan" 2011/2012- 2012/2013 <http://www.doh.gov.za/docs/stratdocs/2011/annual_plan11.pdf> (accessed 13-01-2012)

Department of Justice and Constitutional Development "Uniform National Health Guidelines for Dealing with Survivors of Rape and other Sexual Offences" (1998) 1-2 <http://www.justice.gov.za/policy/guide_sexoff/sex-guide02.html> (accessed 15-02-2011)

Department of Justice and Constitutional Development "National Implementation Plan Service Charter for Victims of Crime" (2007) <http://www.info.gov.za/view/DownloadFileAction?id=123931> (accessed 12-10-2011)

Minister of Health, Dr Aaron Motsoaledi "Department of Health Budget Vote Speech 2012/13: National Assembly, Cape Town" (2012) <http://www.doh.gov.za/show.php?id=3564> (accessed 05/05/2012)

National Directives and Instructions on Conducting a Forensic Examination on Survivors of Sexual Offence Cases in terms of the Criminal Law (Sexual Offences

and Related Matters) Amendment Act 2007 Title GN R 223 in *GG* 31957 of 2009-03-06

National Prosecuting Authority: The Sexual Offences and Community Affairs Unit "Thuthuzela Care Centres: Turning Victims into Survivors" *National Prosecuting Authority News Brochure* (2009) 1-8 <http://www.npa.gov.za/UploadedFiles/THUTHUZELA%20Brochure%20New.pdf> (accessed on 15-02-2011)

Parliament of the Republic of South Africa; Research Unit "Department of Health: The Domestic Violence Act Implementation: Follow up Hearings (2012) 1 1 <http://d2zmx6mlqh7g3a.cloudfront.net/cdn/farfuture/mtime:1334233950/files/docs/120125pcwomen.pdf > (accessed 05-03-2012)

President Jacob G Zuma *State of the Nation Address By His Excellency Jacob G Zuma, President of the Republic of South Africa, at the Joint Sitting Of Parliament* (2011) 1-22 <http://www.parliament.gov.za/live/content.php?Category_ID=337> (accessed 01-03-2011)

President Nelson Mandela "State of the Nation Address 1994" (1994) < http://www.sahistory.org.za/article/state-nation-address-president-south-africa-nelson-mandela> (accessed 12-03-2011)

South African Commission for Gender Equality "Research Report on the Victims' Charter" (2009) 1 23 <http://www.cge.org.za/index.php?option=com_docman&task=cat_view&gid=43&limitstart=5.> (accessed 10-05-2012)

South African Human Rights Commission (SAHRC) "Public Inquiry into the right to have access to Health care services" (2007) 1-92 <http://www.info.gov.za/view/DownloadFileAction?id=99769> (accessed on 13-01-2011)

South African Law Reform Commission "Discussion Paper 102 (Project 107) Sexual Offences: Process and Procedure" (2002) 1, 12

<http://www.justice.gov.za/salrc/dpapers/dp102-execsum.pdf> (accessed 04-07-2011)

South African Law Reform Commission “Issue Paper 25 Project 131 Trafficking in Persons” 1-94 17 <http://www.justice.gov.za/salrc/ipapers/ip25_prj131_2004.pdf> (accessed 12-03-2011)

South African Police Services: Crime Research and Statistics Information Management. “Total Sexual Offences in the Republic of South Africa for April to March 2003/2004 to 2010/2011” 1-2 1 <http://www.saps.gov.za/statistics/reports/crimestats/2011/categories/total_sexual_offences.pdf> (accessed 04-05-2012)

South African research reports

Ally Y (Medical Research Council) "Witch Hunts in Modern South Africa: An Under-Represented Facet of Gender-based Violence" Fact Sheet (2009) 1-2

Bornman S, Budlender D, Vetten L, van der Westhuizen C, Watson J & Williams J (Women's Legal Centre Research Report) "The State of the Nation, Government Priorities & Women in South Africa: Decent Work, Education, Crime, Health, Rural Development & Land Reform" (2012) 1-59

Budlender D & Kuhn J (Centre for the Study of Violence and Reconciliation) "Where is the Money to Address Gender-Based Violence?" (2007) 1-57

Gerntholtz L & Nsibandeby N (Centre for the Study of Violence and Reconciliation) "Using the Law to Secure Women's Rights to Housing and Security of Tenure: A Brief Examination of Some Key Aspects of Family and Customary Law and Domestic Violence Legislation" (2006) 1-19

Christofides N, Webster N, Jewkes R, Penn-Kekana L, Martin L, Abrahams N & Kim J "The State of Sexual Assault Services: Findings from a Situation Analysis" *SAGBVHI Report* (2003) i-49 <http://wiredspace.wits.ac.za/bitstream/handle/10539/3942/M77%20Sexual%20Assault%20Services.pdf?sequence=1.> (accessed 14-07-2012)

Devina P (Tshwaranang Legal Advocacy Centre) "Legal Frameworks obliging a Health Sector Response" in Tshwaranang Legal Advocacy Centre *Developing a Health Sector Response to Domestic Violence* 1-32 http://www.tlac.org.za/images/documents/TLAC_Roundtable_web.pdf> (accessed 04-03-2011)

Gerntholtz L, Meerkotter A, Meyer T, Molefe J, Nsibande N & Vetten L (Tshwaranang Legal Advocacy Centre) "Abused Women's Rights to Access Health Care Services – A Submission to the South African Human Rights Commission Public Inquiry into the Right to have Access to Health care Services" (2007) 6 <http://www.tlac.org.za/wpcontent/uploads/2012/01/Submission-sa-human-rights-

commission-abused-womens-right-to-access-health-care-services.pdf> (accessed 12-01-2012)

Hospital Association of South Africa "Private Hospital Review 2008: Examination of Factors Impacting on Private Hospitals" (2008) 1 67 <http://www.hasa.co.za/media/uploads/documents/file/2011-08-04/HASA_HTG_Final_Report_-_January_2008.pdf> (accessed 12-05-2012)

Kim J, Mokwena L, Ntlemo E, Dwane N, Noholoza A, Abramsky T, Marinda E, Askew I, Chege J, Mullick S, Gerntholtz L, Vetten L, & Meerkotter A "Developing an Integrated Model for Post-rape Care and HIV Post-exposure Prophylaxis in Rural South Africa" (2007) i-46 <http://pdf.usaid.gov/pdf_docs/PNADK615.pdf.> (accessed 12-06-2012).

Lau, U (Medical Research Council) "Intimate Partner Violence Fact Sheet "(2009) *Medical Research Council- UNISA Crime, Violence & Injury Lead Programme* 1-2 <http://www.mrc.ac.za/crime/intimatepartner.pdf> (accessed 05-02-2011)

Liebenberg S "Giving Effect to Human Rights - The Role of the State" in *Human Development and Human Rights: South African Country Study. Human Development Report for the United Nations Development Programme* (2000) 16

Martin LJ & Jacobs T (The Consortium on Violence against Women) "Screening for Domestic Violence: A Policy and Management Framework for the Health Sector" <http://www.ghjru.uct.ac.za/osf-reports/protocol.pdf> (accessed 12-04-2010)

Mathews S, Abrahams N, Martin LJ, Vetten L, Van der Merwe L & Jewkes R (Medical Research Council) "Every Six Hours a Woman is Killed by her Intimate Partner" (2004) 5 *Medical Research Council Policy Brief* 1-4 <http://www.mrc.ac.za/policybriefs/woman.pdf> (accessed 15-02-2011)

Machisa M, Jewkes R, Morna CL & Rama K "Response to Gender-based Violence" in *The War at Home* (2011) 89-108 <http://www.genderlinks.org.za/article/the-war-at-home---gbv-indicators-project-2011-08-16> (accessed 04-05-2012)

Mathews S & N Abrahams (The Gender Advocacy Programme & The Medical Research Council) "Combining Stories and Numbers: An Analysis of the Impact of the Domestic Violence Act (No.116 of 1998) on Women" (2001) 1-34 2 <.http://www.mrc.ac.za/gender/domesticviolence.pdf> (accessed 14-02-2011)

Meerkotter A (Tshwaranang Legal Advocacy Centre) "Domestic Violence, Health and HIV: A Review on the Progress Made in Addressing Domestic Violence Through the *HIV & AIDS and STI National Strategic Plan 2007-2011"* (2009) 3 *Policy Brief* 1 4

Muzenda *G Women Don't Need Sanitary Pads, But Freedom From Gender-Based Violence* (2011) 1-2 < http://www.ngopulse.org/article/women-don-t-need-sanitary-pads-freedom-gender-based-violence> (accessed 29-03-2011)

Nath D (One in Nine Campaign) "We were Never meant to Survive: Violence in the Lives of HIV Positive Women in South Africa" (2012) 25 <http://www.oneinnine.org.za/58.page> (accessed 04-06-2012)

National Working Group on Sexual Offences "Submission to the Department of Justice: Regulations in terms of the Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007" (2008) 1-12 <http://www.tlac.org.za/wp-content/uploads/2012/01/nwgso-submission-on-sexual-offences-act-regulations.pdf> (accessed 15-04-2012)

Parenzee P, Artz L & Moult K "Monitoring the Implementation of the Domestic Violence Act: First Research Report 2000-2001" (2001) 1-138 <http://www.ghjru.uct.ac.za/osf-reports/dva-report.pdf.> (accessed 05/09/2011)

Pearmain D "Health Policy and Legislation in South Africa" (2007) 19 24 <http://www.hst.org.za/uploads/files/chap2_07.pdf> (accessed 12-02-2012)

People Opposing Women Abuse (POWA), and others "Criminal injustice: Violence against women in South Africa" (2010) 1-26 <http://www2.ohchr.org/english/bodies/cedaw/docs/ngos/POWA_Others_SouthAfrica48.pdf> (accessed 21-02-2011)

Rural Health Advocacy Project, Budget Expenditure Monitoring Forum, SECTION 27 and Africa Health Placements "Press Statement: Austerity Measures Imposed on Eastern Cape Department of Health a Disaster for Rural Healthcare Delivery" (2012) <http://www.rhap.org.za/wp-content/uploads/2012/05/Statement-about-EC-Budget-crisis_17-May-2012_RuDASA_-RHAP_-BEMF_SECTION27_AHP.pdf.> (accessed 22-05-2012).

Section 27 "The Statutory and Administrative Framework of the Public Health System" in *Health and Democracy* (2010) 94-125 <http://section27.org.za.dedi47.cpt1.host-h.net/2007/06/01/health-and-democracy/> (accessed 12-06-2012)

South African Commission for Gender Equality "Research Report on the Victims' Charter" (2009) 1 23 <http://www.cge.org.za/index.php?option=com_docman&task=cat_view&gid=43&limitstart=5.> (accessed 10-05-2012)

Tshwaranang Legal Advocacy Centre "Submission to the Portfolio Committee & Select Committee on Women, Youth, Children and People with Disabilities: Implementation of the Domestic Violence Act 116 of 1998" (2009)1-10 <http://www.tlac.org.za/wp-content/uploads/2012/01/Submission-health-sector-response-to-domestic-violence.pdf> (accessed 12-04-2011)

Vetten L (Centre for the Study of Violence and Reconciliation) "Man Shoots Wife: Intimate femicide in Gauteng in South Africa" (1996) 6 winter *Crime and Conflict* 1-4 <http://www.csvr.org.za/wits/papers/papvet1.htm> (accessed 14-01-2011)

Vetten L & Bhana K (Centre for the Study of Violence and Reconciliation) "Violence, Vengeance and Gender: A Preliminary Investigation into the Links between Violence against Women and HIV/AIDS in South Africa" (2001) 1 4 < http://www.csvr.org.za/wits/papers/paplvkb.pdf> (accessed 06-03-2012)

Vetton L "Addressing Domestic Violence in South Africa: Reflections on Strategy and Practice" (2005) 1-12 10 < http://www.un.org/womenwatch/daw/egm/vaw-gp-2005/docs/experts/vetten.vaw.pdf > (accessed 12-04-2011)

Vetten, L (Tshwaranang Legal Advocacy Centre) “Outlining the Rationale for a Health Sector Response to Domestic Violence” in *Developing a Health Sector Response to Domestic Violence: A Roundtable Discussion* (2008) 1-32 <http://www.tlac.org.za/images/documents/TLAC_Roundtable_web.pdf> (accessed 04-03-2011)

Vetten L, (Tshwaranang Legal Advocacy Centre) “Of Taxis and Trials: Snapshots from the Struggle for Gender Equality” 48 49 (2008) <http://www.tlacporg.za/index.php?option=content&task=view&id=250> (accessed 12-06-2011)

Vetten L, Kim J, Ntlemo E & Mokwena L “From Paper to Practice: Lessons in the Implementation of Health and Victim Empowerment Policy Applicable to Rape Survivors” (2009) *Policy Brief 2 2* <http://www.tlac.org.za/wp-content/uploads/2012/01/Policy-Brief-from-paper-to-practice.pdf> (accessed 12-04-2012)

Vetten L, Le T, Leisegang A & Haken S “The Right and the Real: A Shadow Report Analysing Selected Government Departments’ Implementation of the 1998 Domestic Violence Act and 2007 Sexual Offences Act” (2011) 1 3 <http://www.boell.org.za/downloads/The_Right_and_The_Real.pdf> (accessed 12-10-2011)

Doctoral Dissertations

Joyner K *Health Care for Intimate Partner Violence: Current Standards of Care and Development of Protocol Management* DPhil thesis Stellenbosch University (2009)

Pieterse M *A Benefit-Focused Analysis of Constitutional Health Rights* DPhil dissertation University of Witwatersrand (2005)