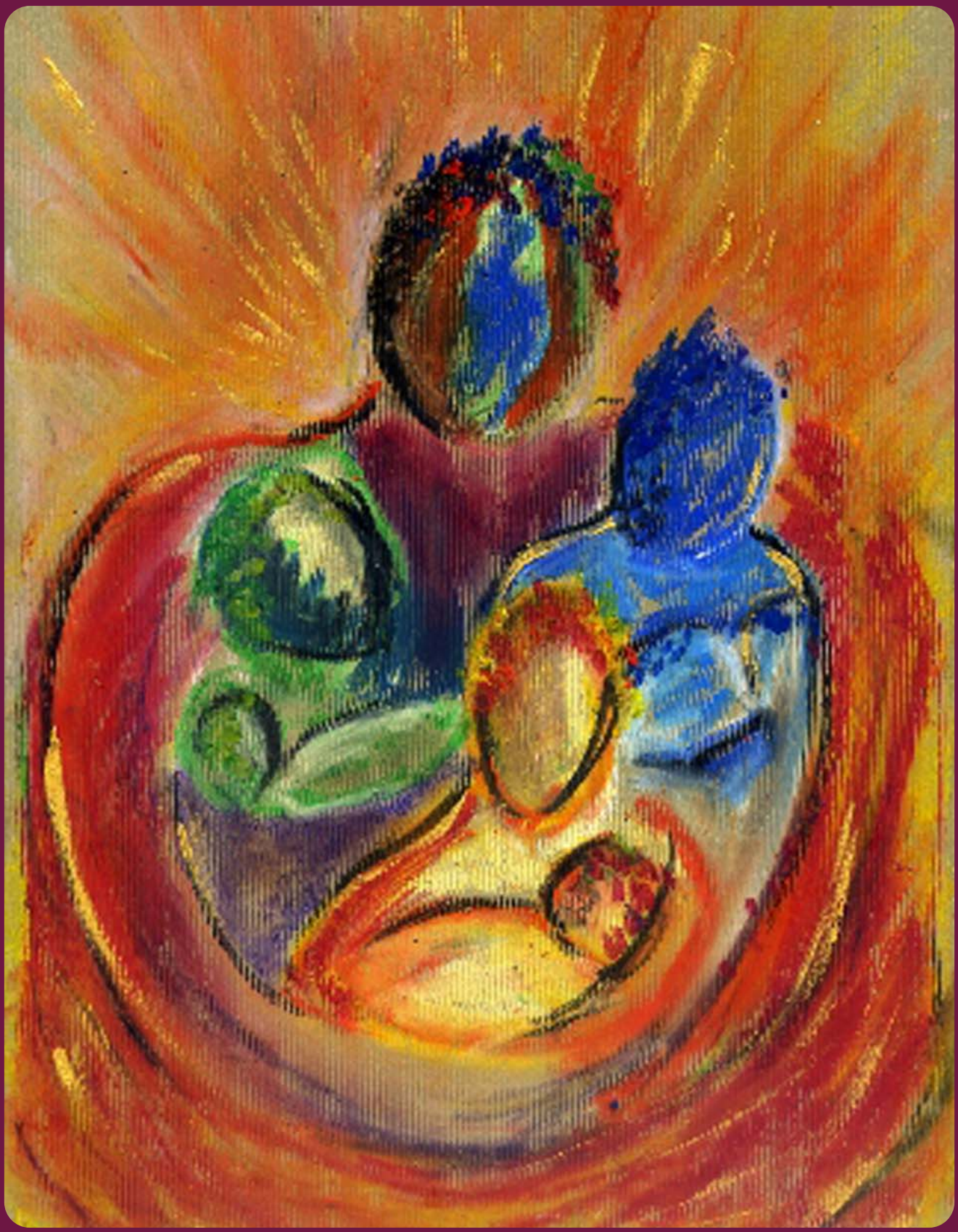


A different kind of family

Anushka Virahsawmy

CHAPTER 6

Health

Article 26

Care workers celebrating World Aids day at a function held in Orange farm, Gauteng. *Photo: Gladys Muzirwa*

KEY POINTS

- South Africa is ranked second in the SGDI and the CSC score in the health sector at 81% and 78%.
- The mortality rate is 176 per 100 000 live births.
- 60% women who are sexually active have access to contraceptives.
- Choice of Termination of Pregnancy is legal in South Africa and is freely available at state clinics and hospitals.
- The rate of foetal alcohol syndrome is extremely high.
- Sanitation is a challenge in South Africa especially the right to access dignified ablution facilities.

Table 6.1: SGDI and CSC scores on health		
	SGDI	*CSC*
Scores	81%	78%
Ranks	2	2

South Africa has in place a Constitutional framework that endorses the right to health. In 1994 the new democratic government put in place policies and programmes aimed at improving maternal health in South Africa. South Africa is a signatory to a wide range of treaties and conventions that promote maternal health.[1]

At 81%, South Africa scores second in the SADC region using the SGDI that measures:

- Women using contraception - the percentage of women aged 15 to 49 years reporting that they use a modern form of contraception;
- Maternal mortality ratio - the number of women who die while pregnant or within 42 days of termination of pregnancy for every 100,000 live births of babies; and
- Births attended by skilled personnel - the percentage of births in a given year in which women are assisted by trained staff such as midwives or nurses.

This empirical measure is testimony to the country's huge investment in the health care system, which is rated as one of the best and most comprehensive in Southern Africa. At 78%, the Citizen Score Cared (CSC), based on perceptions, score is lower than the SGDI, but relatively higher than other CSC sector scores. Government efforts aimed at improving the health of mothers, young children and adolescents, as well as men, are bearing fruit. But there are still challenges with regard to accessing quality health care facilities. Table 6 summarises key gender and health indicators, referred to in greater depth throughout the chapter.

Table 6.1: Key sexual, reproductive and health indicators

Indicator	Country statistic/policy	Comment
Current maternal mortality rate (deaths per 100 000 live births)	176	Although this is high by global standards, it is one of the lowest rates in the SADC region. Prevalence of HIV has been found[2] to play a significant role in the high MMR of the region.
% Births attended by Skilled Personnel	92%	This is the fourth highest in the region - Seychelles, Mauritius and Botswana rank higher.
% Contraceptive use among sexually active women	60%	This is the second highest in the region after Mauritius. However this is a 5% decrease from 2012.
Country policy on abortion	Choice on Termination of Pregnancy Act	South Africa is the only country in the SADC region where choice of termination of pregnancy is fully legal.
% Total coverage of sanitation facilities	59%	Only Mauritius and Seychelles are ranked higher, but coverage is generally low in the region. Service delivery has been an issue of much tension in South Africa.
% Urban coverage	86%	This is relatively high for the region, but pressure mounts as domestic migration from rural to urban areas increases.
% Rural coverage	44%	While the country is ranked third for urban coverage, it is ranked only sixth in the region for rural coverage and is lagging behind its urban counterpart by a 42%.

Source: SADC Gender Protocol 2010 Barometer (UNAIDS.ORG).

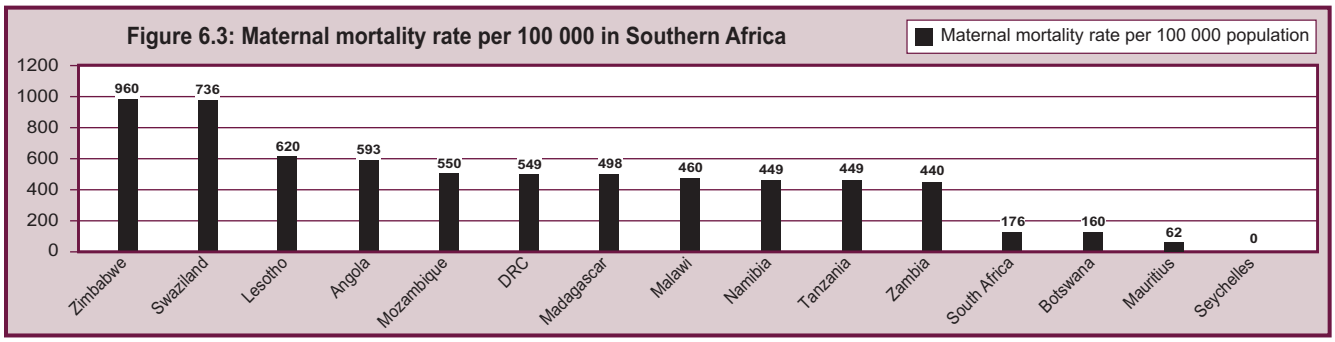
Sanitation

The Protocol provides for state parties to by 2015, adopt and implement legislative frameworks, policies, programmes and services to enhance gender sensitive, appropriate and affordable quality health care; reduce the maternal mortality ratio by 75% and ensure the provision of hygiene and sanitary facilities.

1 Millennium Development Goals Country Report 2013.
2 The Lancet, volume 375 No.9730 (www.TheLancet.com).

- ***Negligence:*** Many women give birth to stillborn babies because of the negligence of staff. Women must be educated about their rights as patients. In an event that those rights are violated, women must be supported and encouraged to take appropriate legal action against health care institutions.
- ***Lack of empathy:*** Shortage of staff should not compromise the health and integrity of women needing care. The Department of Health must lead a campaign on Batho Pele Principles to improve the quality of care that ordinary citizens receive.
- ***Lack of appropriate staff training*** in relation to their area of specialisation. For example, there are only a few trained advanced midwives in South Africa. Such training could alleviate the shortage of doctors.

The Maternal Mortality ratio is the number of women of child bearing age who die during pregnancy or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes per 100 000 live births[3]. While global and continent wide attention has been focused on reducing the maternal mortality ratio (which is also a Millennium Development Goal - number 5), this ratio has increased in seven Member States (Botswana, South Africa, Swaziland, Zambia, Lesotho, DRC and Zimbabwe)[4] Southern African countries, mainly as a result of HIV and instability. Increased access to HIV treatment and care is beginning to reverse the trend but the rate of decrease is too slow to meet the goals of either the Gender protocol or the MDGs by 2015 and will require much greater effort on the part of most Member States.



Source: SADC Gender Protocol Barometer, 2013.

Maternal mortality varies widely in the SADC region: Figure 6.1 reveals high levels of maternal mortality throughout the SADC region, but these vary from no deaths of mothers at child birth in the period under review in Seychelles to some of the highest levels in the world, for example in Zimbabwe (960 deaths per 100 000 births). At 176 per 100,000 the maternal mortality rate in South Africa is among the four lowest in the region.

Maternal mortality and morbidity exacts a heavy cost on society: The consequences of maternal mortality and morbidity are felt not only by women but also by their families, communities and nations. If a woman dies in pregnancy or childbirth, the baby is much less likely to survive or has an increased risk of having a disability. Children who lose their mothers are at increased risk of death or other problems later in life such as malnutrition and lack of education. Loss of women during their most productive years also means a loss of resources for the entire society; increased single parent families, reduced labour force and reduced economic productivity.

In South Africa, maternal mortality is less of a concern than in the past. However, high rates of alcoholism result in a high rate of Foetal Alcohol Syndrome (FAS) especially in the Western Cape and Gauteng provinces. FAS, which is caused by excessive alcohol intake during pregnancy, results in physical and mental defects, characterized by growth retardation, facial neural abnormalities and malformation of other organs. According to a Department of Health pamphlet (2006) FAS affects one out of every 750 babies born in South Africa. The Foundation for Alcohol Related Research (FARR) has reported a steady increase of FAS at Western Cape (4.8% to 7.6%). Studies in Gauteng, the most urbanized of South Africa's nine provinces, have reported a prevalence of 8.8% in Soweto; 2.2% in Lenasia and in 3.7% in Westbury.

[3] MMR definition.
[4] AUC, UNECA, AfDB & UNDP. 2013. MDG Report 2012. Pg 68.

Protocol @ work

Fighting Foetal Alcohol Syndrome

The South African National Council on Alcoholism & Drug Dependence (SANCA) Phoenix House, an NGO based in Westbury, Johannesburg, has joined forces with the City of Johannesburg to raise awareness about FAS and reduce its incidence. Pheonix House provides educational talks with posters, pamphlets and other materials in various languages, to ante natal mothers in seven City of Johannesburg community health clinics.

Phoenix House coordinator Lena Sibanda told the SADC Protocol@Work Summit in April 2013 that the NGO has been able to overcome the challenges of limited funding, understaffed clinics and language barriers to reach 15 000 pregnant women per annum with information about the dangers of FAS for their children. The programme has been replicated in Mid Rand and could be extended further with the necessary funding as materials are already available.

SANCA aims to empower volunteers and health care promoters at community clinics in Johannesburg through specialised training on FAS; implement an educational discussions at ante natal clinics on FAS through talks, presentation materials, posters and literature in different languages and for illiterate people; as well as provide information on substance abuse in general especially because some of these women are in relationships with partners abusing it.

The primary beneficiaries of the project are pregnant women between 15 to 40 years of age that are not able to afford private health care and make use of community clinics for their check-ups. Other patients at the clinics

also participate while waiting for their medical needs to be met. The project reaches 15 000 pregnant women per annum.

Challenges include lack of funding to reach all the clinics as well as to pay for the stipends of volunteers. Reports suggest that some women drink to affect their babies so that they can claim the disability grants that are more than child support grants. Literature on FAS is not available in all the official languages of South Africa. Johannesburg also has a high proportion of migrant workers who speak French or Portuguese as their first languages. Clinics have staff shortages and high burn out rates.

Nonetheless, Phoenix House has duplicated its programme at a satellite office in Ebony Park, Midrand where the FAS programme is being implemented in five community clinics.

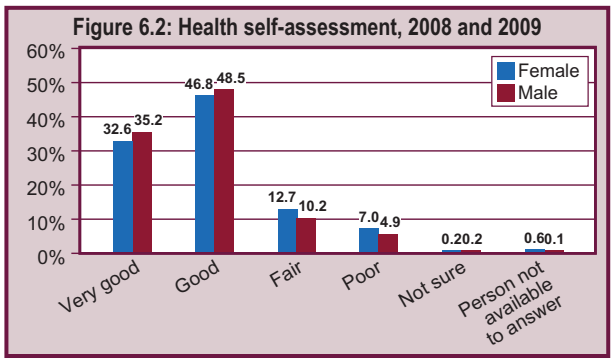
Access to quality health services

Inadequate access to quality health services is a major contributing factor to high maternal mortality rates. Some of the factors that contribute to access are: distance to the health facility, infrastructure, numbers of skilled staff available, attitudes of health staff, traditional beliefs and customs, availability of services at the facilities and cost of services Women who have access to health services are much more likely to have at least one and the recommended four ante natal visits; to deliver with a skilled health assistant and to have follow up or post natal care for themselves and their infants. Access to at least four ante natal care visits has been shown to have a very strong correlation with reduction in maternal mortality rates. Antenatal care should include screening for and management of infections, hypertension, iron deficiency and other risk factors, tetanus toxoid vaccination and testing for HIV.

The level of maternal mortality is a concern to the South African government as expressed in its population policy and the Negotiated Service Delivery Agreement (NSDA) of 2010-2014. The NSDA is a charter that reflects the commitment of key sectoral and intersectoral partners linked to the delivery of identified outputs as they relate to a particular sector of government. The Government has agreed on 12 key outcomes as the key indicators for its programme of action for the period 2010 - 2014. Each outcome area is linked to a number of outputs that inform the priority implementation activities that will have to be undertaken over the given timeframe to achieve the outcomes associated with a particular output. The Department of Health has put in place a number of extensive policy initiatives aimed at reducing maternal mortality and improving the quality of health care throughout the health care system[5].

[5] Millennium Development Goals Country Report 2013.

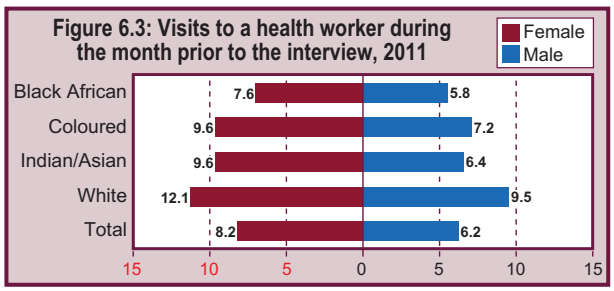
Health assessment



Source: LCS 2008/2009.

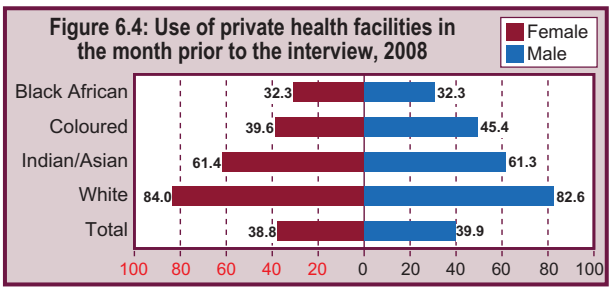
Figure 6.2 shows the percentage of South African women and men who rate their health as 'very good', 'good', and 'fair' or 'poor'. It shows that close to half of both women and men self-rate their health status as 'good', followed by about a third who self-rate their health as 'very good'. However, a larger proportion of men than women rate their health as either 'good' or 'very good', while women are more likely than men to rate their health as 'fair' or 'poor'.

Visits to health workers



Source: GHS 2011.

Figure 6.3 shows that among both women and men, white people are more likely than those in other population groups to have visited a health worker in the past month. At the other end of the continuum, among both women and men, black African people are least likely to visit a health worker. Across all four population groups, women (8,2% for all groups combined) are more likely than men (6,2%) to have visited a health worker. This pattern is expected, as in addition to other health care-related needs, women tend to have more needs than men for reproductive health care, including health care related to pregnancy and childbearing.



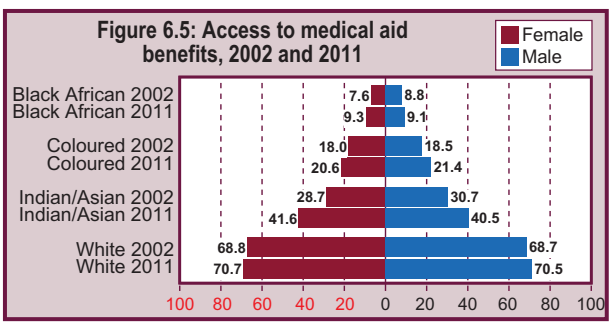
Source: GHS 2011.

Figure 6.4 reveals that, among those using health facilities in the past month, white women (84,0%) and men (82,6%) are most likely to use private health facilities, followed by Indian/Asian women (61,4%) and men (61,3%).In contrast, among black African women and men who used health facilities in the past month, only 32,3% used private health facilities.

Within each population group, there is only a small difference between the percentage of women and the percentage of men who use private health facilities. Overall, South African men (39,9%) are slightly more likely than women (38,8%) to visit private health facilities when they need health care.

- Lack of effective ambulance services in townships and rural villages. *Recommendation:* Provide adequate support for Municipal medical and paramedical services.
- Unaffordable and inaccessible health care services for pregnant women. *Recommendation:* Finalise initiatives for health care insurance for all people in South Africa.

Health assessment



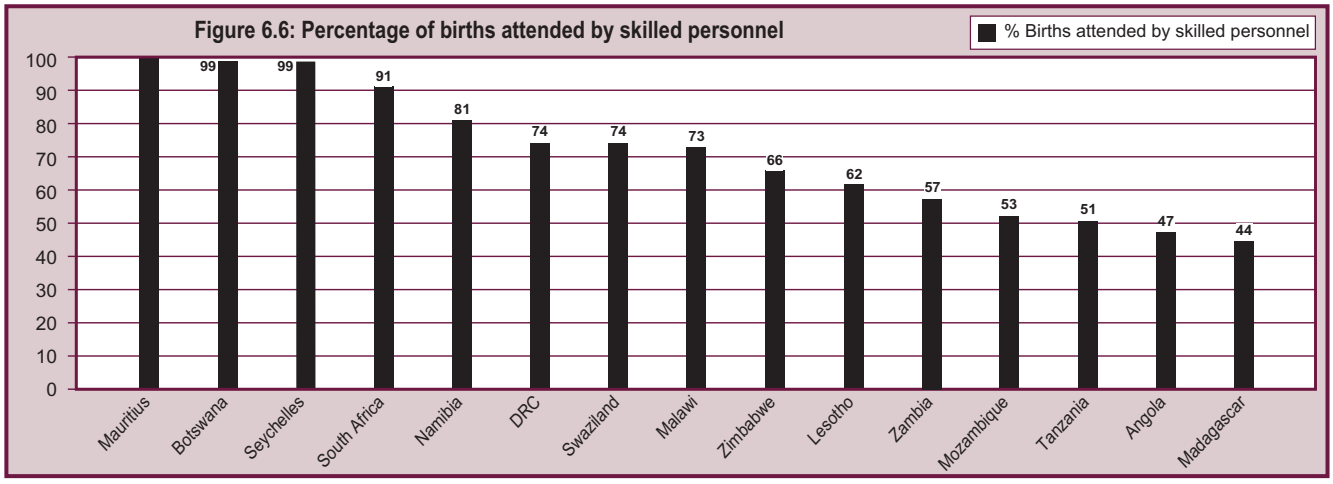
Source: GHS 2011.

Figure 6.5 shows that in both 2002 and 2011, white women and men were far more likely than other population groups to have access to medical aid benefits. For men in 2011, access ranged from 9.1% for black African men to 70.5% for white men. For women in 2011, access ranged from 9.3% for black African women to 70.7% for white women. For both 2002 and 2011, gender differences in access to medical benefits are small within each population group. Access to medical aid benefits appears to have increased between 2002 and 2011 in all four population groups, and for both women and men.

Access to skilled health professionals

African countries such as Equatorial Guinea, Mauritius, Egypt, Morocco, Cape Verde, Tunisia, Ethiopia, Algeria, Rwanda and Mauritius have made significant progress in reducing the maternal mortality rate. One of the most important changes that these countries have made is to increase the proportion of births which are attended by a skilled health attendant as many of the conditions that cause maternal mortality can be prevented with medical assistance. Increasing the percentage of births attended to by skilled health professionals' results in the decrease of maternal mortality rates.

- Negative attitudes and condemnation for women who choose to terminate their pregnancies weighs heavily on women.
- Use of traditional herbs coupled with women's reluctance to use modern ante-natal clinics affects women's health.
- Registration and further training for traditional healers including traditional birth attendants is necessary.
- Older women are reluctant to be examined by young nurses.
- Some women refuse to have blood transfusions for religions reasons. Other refuse to either use contraceptives and/or undergo surgery in case of reproductive health complications. The Department of Health should collate research on traditional and religious beliefs/practices that impact on women's health during pregnancy and childbirth.



Source: SADC Gender Protocol Barometer, 2013.

Figure 6.6 shows that the percentage of births attended by a skilled health professional varies from a low of 44% in Madagascar to a high of 100% in Mauritius. Four countries have more than 90 % of births attended by a skilled health professional while five have fewer than 60%. At 91%, South Africa ranks fourth in the SADC region.

Sexual and reproductive health

By 2015 countries should develop and implement policies and programmes addressing mental, sexual and reproductive health needs of women and men.

Where sexual and reproductive health had previously been treated as an issue within the domain of health care and service access, the definition of sexual and reproductive health adopted at the International Conference on Population and Development (ICPD) reads as follows:

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

Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the rights of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right to access appropriate health care services that will enable women to go safely through pregnancy and child-birth and provide couples with the best chance of having a healthy infant.

In line with the above definition of reproductive health, reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems.

It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproductive and sexually transmitted disease"

Source: International Conference Population and Development report, para 7.2

In 1995, at the Fourth World Conference on Women (FWCW) in Beijing, the international community agreed that human rights include the right of women to have control over their sexuality. Increasingly, the terms sexual and reproductive rights have been used in policies and programmes throughout the world.

According to the International Conference on Population and Development (ICPD), the reproductive health approach recognises women as subjects rather than objects; upholds their dignity; respects their free and informed choices; and responds in a comprehensive manner to the totality of their health needs. It also aims to promote men's understanding of their roles and responsibilities regarding reproductive health and aims to address the reproductive health issues of adolescents which were largely neglected under traditional family planning policies. Furthermore, it addresses the issues of HIV and AIDS and sexually transmitted infections as part of its discourse.[6]

Key challenges to attaining sexual and reproductive health are HIV and STIs, unintended pregnancy and abortion, infertility and cancer resulting from STIs and sexual dysfunction. Gender inequality and gender-based violence also impact significantly on the attainment of sexual and reproductive rights for women and girls.

Source: OSISA, http://www.osisa.org/buwa/south-africa/sexual-and-hivaids-education-south-african-secondary-schools

Women globally and in Southern Africa suffer from lack of control over their own sexuality[7]. As it is intimately related to economic independence, this right is most violated in those places where women exchange sex for survival as a way of life. This is not about prostitution but rather a basic social and economic arrangement between the sexes which results on the one hand from poverty affecting men and women, and on the other hand, from male control over women's lives in a context of poverty. By and large most men, however poor, can choose when, with, whom and with what protection, if any, to have sex. Most women cannot exercise these same choices.

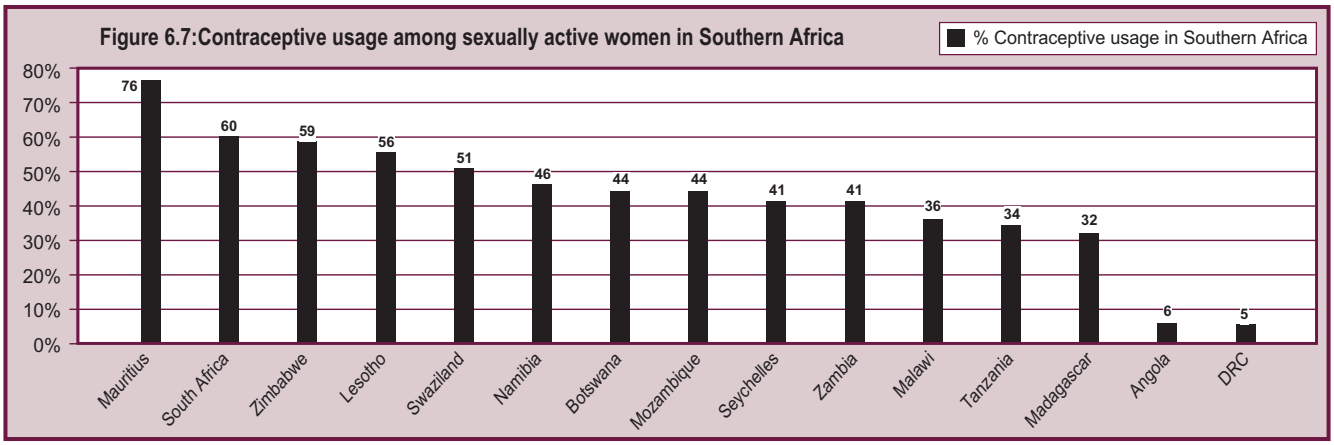
HIV positive women experience violence, abandonment, neglect (of health and material needs), destitution, ostracism from family and community. Furthermore, women are often blamed for spread of disease, always seen as the "vector", even though the majority are infected by their partner or husband.

Violence against women has serious consequences for physical and mental health: Abused women are more likely to suffer from depression, anxiety, psychosomatic symptoms, eating disorders, and sexual dysfunctions. Violence may affect the reproductive health of women through: the increase of sexual risk-taking among adolescents; the transmission of STIs; including HIV and AIDS; unplanned pregnancies; various gynaecological

6 ICPD 1999.
7 This section borrows from an article, " Women's health at risk in Africa." Afrol News http://www.afrol.com/Categories/Women/backgr_health_at_risk.htm

problems including chronic pelvic pain and painful intercourse. Consequences such as HIV and AIDS or unplanned pregnancies may in themselves act as risk factors for further aggression, forming a cycle of abuse. Effects of violence may also be fatal as a result of intentional homicide, severe injury or suicide.

The Constitution provides for the right to health care services, including reproductive health care. Strategies for the sexual and reproductive health policy in South Africa include the integration of programmes and services targeting sexually transmitted infections, and those targeting sexual and reproductive health and rights (including reproductive cancers). This is intended to maximize resource utilization and attain effective synergy between the two areas (STIs, and sexual and reproductive health and rights). Repositioning family planning as an essential part of the MDGs, and addressing sexual and reproductive health and rights of adolescents and youth is a key part of the strategy.



Source: 2013 SADC Gender Protocol Barometer and WHO 2013 report.

Figure six shows that at 60% South Africa has the second highest level of contraceptive usage in Southern Africa. Five member states have contraceptive usage of over 50%: the region is led by Mauritius at 76%, followed by SA, Zimbabwe at 59%, Lesotho and Swaziland at 56 and 51% respectively. The DRC and Angola have the lowest usage at 5% and 6%, the UNFPA has estimated that a third of maternal deaths could be prevented if all women were able to access contraceptives; this is obviously an area where much effort needs to be invested.

Condoms

In South Africa, the health system freely distributes the male condom and civil society and the private sector are also using their own platforms and spaces to distribute and provide alternative access points to the male condoms distributed by the Department of Health. As a result, one seldom goes anywhere without seeing a full or empty male condom box or dispenser in many public spaces.

There have been campaigns to distribute female condoms but the issue that is often raised about the female condom is that it is not as easy to use as the male condom. This suggests that there might be more uptake of the female condom is if it is coupled with education on how to make use of it. Also, where it is sold instead of given freely, it is more costly than male condoms that are for sale.

In general, therefore, there is less knowledge on how to use female condoms, less awareness of their existence, they are far less frequently distributed free of charge (only at health centres), and where they are for sale, they are more expensive than male condoms.

It is important to note here too that access to condoms is just one piece of the puzzle. Increasingly, campaigns and initiatives are deliberately targeting men to become actively involved in protected sex, and South Africa does have the second highest contraceptive usage for the region (see figure 6.4), but there are still enormous challenges. Attitudes, opinions and cultural norms will determine the extent to which condoms and other forms of contraception are actually used. Gender inequality and gender-based violence impact significantly on the attainment of sexual and reproductive rights for women and girls, and negotiating safer sex is often not possible for women and girls due to their lived realities within the social hierarchy.

Termination of Pregnancy

The Choice on Termination of Pregnancy Act of 1976, implemented in 1977, allows a woman or girl of any age to request an abortion within the first 12 weeks (first trimester) of their pregnancy, without the knowledge or consent of their parents or partner. In the fifteen years that the Act has been in force much has been achieved to implement the provisions of the Act. By the end of 2012, 57% of designated facilities provided

safe Termination of Pregnancy services, exceeding the target that had been set of 45% of designated facilities.[8] This has resulted in a great increase of terminations of pregnancy in health facilities and a corresponding reduction of unsafe "back street" abortions. While backstreet abortions still occur, deaths of women resulting from them have been almost eliminated. However, stigma, discrimination and negative attitudes of providers still make access to safe termination of pregnancy difficult, especially for adolescents. Health services need to increase access to contraception to prevent unwanted pregnancies rather than using abortion as a means of contraception.

Women's body a women's right

In the period leading up to the enactment of the Choice on Termination of Pregnancy Act of 1996, there were heated debates involving a cross-spectrum of voices. Women's rights, reproductive health, pro-life issues, gender issues and various other topics rose to the surface. When the Act was finally ratified, its promulgation resulted in a 91% drop in abortion-related deaths between 1994 and 2001.

The debate that often resurfaces is one that pertains to the still ongoing occurrences of unsafe "backroom" abortions and the detrimental health consequences they have for the women concerned.

The South African Choice of Termination of Pregnancy Act (CPTA) is also one of the world's most liberal abortion laws, and would not have come about if women were not in key decision-making roles.

Key provisions of the act are that:

- Abortion should be available to all women, upon request, up to 14 weeks.
- From 14 to 24 weeks, abortion should be available under certain conditions.
- The state should provide information on abortion, pre and post counselling.

ANC Chief Whip from 2001-2002, Nathi Nhleko, maintained that the legislation, that evoked strong emotion from every political and religious persuasion, would "most definitely not have come about without the substantial presence of ANC women, but also because the ANC took a strong position, rooted in the Constitution, and defended that position."

"It is one of the bills that may never, or would have taken a very long time to pass if women had not been there," added the then Chair of the Joint Committee in Improvement of Quality of Life and Status of Women, Lulu Xingwana.

"The intersections were interesting," observed the then Deputy Defence Minister Nozizwe Madlala-Routledge, then chair of the PWG. "We were able to find common ground with some women, with others it was very much determined by party policy. What we did do (as ANC women) was use our majority and get the support of the men in the party so we could pass this law. But there was support from many individuals in other parties; it was not just the ruling party alone." - *Ringing up the Changes*

The Department of Health notes that since provision of access to choice in termination of pregnancy, 344,477 women over a seven year period (1997-2004) availed themselves of the services. A University of Cape Town study[9] in 2006, however, found that thirty-two percent of women did not know that abortion is currently legal, and among those who knew of legal abortion, few had knowledge of the time restrictions involved.

While this is not an issue provided for in the Protocol, it is being debated increasingly throughout the SADC region. With only South Africa (and to some extent Zambia) having legalised abortion, there is obviously still great resistance to the issue across the region. However, given that illegal abortion is one of the main reasons behind high maternal mortality rates throughout the region and the fact that there are many unplanned pregnancies throughout the region, it is clear that there needs to be more dialogue about abortion in the SADC region.

Sexual Orientation

Although the definition of sexual and reproductive health emphasises the need for all people to be able to have safe and satisfying sex, the majority of Southern African countries consider homosexuality to be illegal. A hotly contested issue in the negotiations, sexual orientation is not provided for in the Protocol. However, South Africa has invalidated the prohibition against same-sex relationships. South African organizations who work with the rights of homosexual individuals provide safety packs as a way of minimizing the spread of HIV.

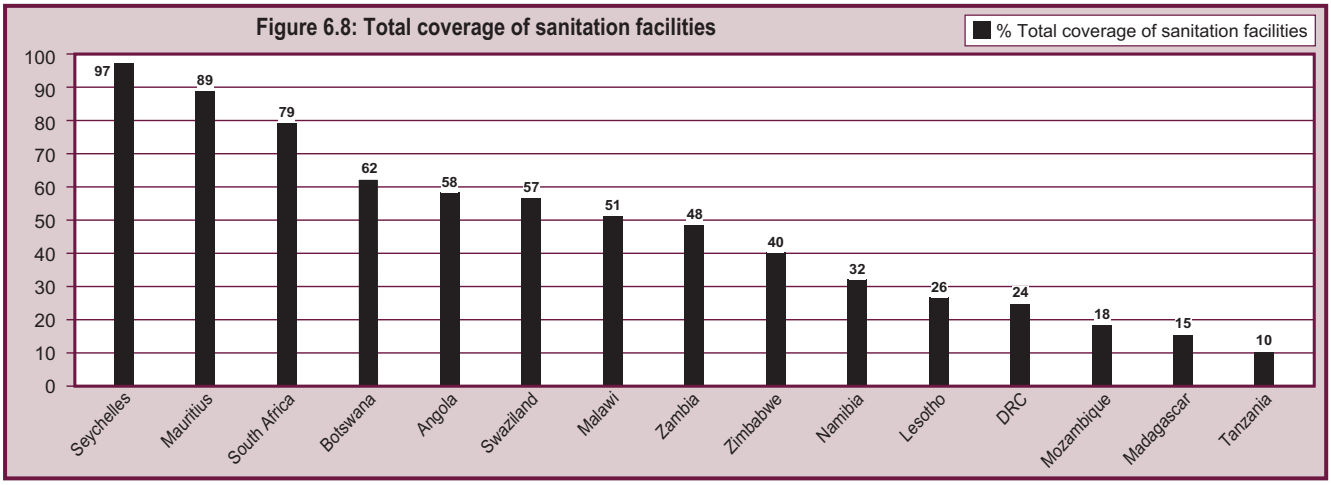
8 Department of Health. Annual Report 2012. Pretoria 2012.
9 http://www.reproductive-health-journal.com/content/3/1/7

Sanitation

The Protocol requires that by 2015 Member States ensure the provision of hygiene and sanitary facilities and nutritional needs of women, including women in prison.

The provision of sanitation and hygiene facilities is integral to improving women's health throughout the region. Poor sanitation results in increased spread of communicable diseases which women are particularly vulnerable to. Furthermore, menstruation, pregnancy, and post-natal care are difficult for women without proper hygiene and sanitary facilities, as does caring for family and community members living with HIV. According to the World Health Organization, almost one tenth of all gl obal deaths can be avoided by providing clean drinking water, better sanitation and improving water resources management to reduce the incidence of water-borne diseases and cases of accidental drowning.

Legedia Matee says she has lost hope that the council will one day complete building her toilet. *Photo: Tsheko Kabasia, Sowetan*



Source: SADC Gender Protocol Barometer, 2013.

Figure 6.8 shows that South Africa (79%) comes third in the coverage of sanitation facilities after Seychelles (97%) and Mauritius (89%). Six of the 15 countries have less than 50% coverage in urban areas and ten of 15 countries have less than 50% coverage in rural areas.

Sanitation in South Africa has been a major issue in the protests against the lack of service delivery in the country. Leading to the local government elections in 2011, sanitation riots rose in SA due to a lack of dignified sanitation services in the form of un-enclosed toilets in Khayelitsha (Western Cape Province) and in Rammulotsi, Free State Province. Political parties in the Western Cape lodged complaints with the South African Human Rights Commission (SAHRC) and the Cape High Court.

The SAHRC also received a complaint concerning the state of sanitation in Rammulotsi. Both the Cape High Court and the South African Human Rights Commission (SAHRC) found that in both cases the sanitation services (or inadequacy thereof) violated the right to human dignity, privacy and the rights to a clean environment, and in both cases, the relevant municipalities were ordered that the existing toilets be enclosed as a matter of urgency.

The right to sanitation

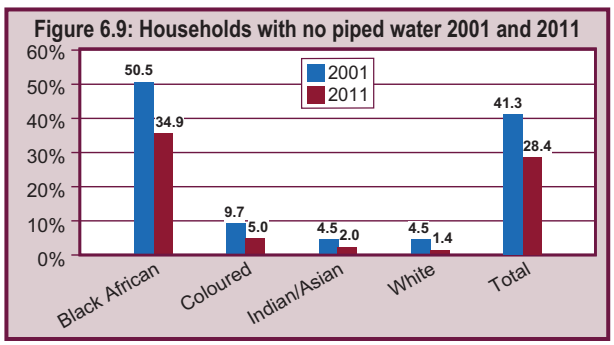
In a country with an economic gap as wide as that of South Africa, sanitation is couched in the broader debates around access, poverty, service delivery and health. In 2010 violent conflict erupted in the Western Cape over sanitation. The previous year, the Cape Town City Council installed unenclosed toilets for 1316 families in Makhaza, Khayelitsha.

The Water Services Act stipulates the following regarding the minimum standard for basic sanitation: "a toilet which is safe, reliable, environmentally sound, easy to keep clean, provides privacy and protection against the weather, well ventilated, keeps smells to a minimum and prevents the entry and exit of flies and other disease-carrying pests."

Despite the abject poverty of the area, most of the families chose to spend their resources on enclosing the toilets rather than suffer the indignity of using them without enclosures. For 53 of the families, however, this was not possible and their toilets remained unenclosed. After that, violent conflicts erupted between residents and local government officials, with other political factions embroiling themselves in the conflict too.

This case illustrates the fact that sanitation is not just about the basic provisions. It is about health, human dignity and access to facilities, service delivery and justice.

Access to water



Source: LCS 2008/2009.

Figure 6.9 shows that a minority of South Africans do not have access to piped water inside their dwelling or on site. It shows further that the proportion without such access fell sharply between 2001 and 2011, from 41,3% to 28,4%.

Significant differences in access remain between black African households and other population groups. In 2001, 50,5% of black African households were reliant on off-site sources for water. By 2011, the percentage had dropped to 34,9%. This is still high when compared to other population groups for whom the percentage is less than 10% for both 2001 and 2011.

Among coloured, Indian/Asian and white households the percentage without access also decreased between 2001 and 2011. However, coloured households continue to have poorer access to piped water on site than Indian/Asian and white households.

Women in prisons and refugee camps

Globally there were 10.5 million refugees at the end of 2012. Of the 10.5 million refugees 1.1 million came from the DRC, Somalia, Mali, Sudan and the Syrian Arab Republic in 2012 - the highest annual figure since 1999.[10] Sub Saharan Africa hosted 2.8 m or nearly 25% of all refugees. In June 2012, UNHCR stopped awarding refugee status to people who fled the conflict in Angola and 20 000 refugees returned to Angola. From 2006 to 2011, South Africa was the country with the highest number of asylum seekers in the world, but the numbers declined by 42% in 2012 compared to 2011. There were 778 600 new asylum applications in South Africa from 2008 and 2012, with almost half a million of these being Zimbabwean. Girls and women who are in countries which are at risk of, in the midst of, or emerging from armed conflict often experience rape and are forced into sex work: high risk situations for contracting HIV or becoming pregnant. The health facilities in refugee camps are generally poor, with few qualified nurses and supplies.

[10] UNHCR 2012.

Next steps

- Focus more attention on health services and sanitation for rural and lower income populations to address the disparities in provision of health services and sanitation between urban and rural as well as higher income and lower income populations.
- Greater involvement of women in health and sanitation programmes. Because women benefit the most from improved health and sanitation, their involvement is important for programme success and sustainability.
- Hold government accountable in providing services to its citizens.
- Adopt strategies to ensure that the distribution of female condoms at no cost needs to be implemented.
- More awareness and campaigns need to target women in teaching them on how to use the female condom.