A different kind of family

Anushka Virahsawmy
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.
At a rank of 81% on the SGDI, South Africa ranks second in the SADC region in this category. The SGDI 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 trained staff such as midwives or nurses assist women giving birth.

This empirical measure is testimony to the country's huge investment in the health care system, which experts have rated as one of the best and most comprehensive in Southern Africa. However, at 64% the CSC score is much lower than the SGDI score, and a drop of 14 percentage points from the 2013 score of 78%. While government efforts aimed at improving the health of mothers, young children and adolescents, have seen success, this citizen ranking underscores the challenges that still exist with regard to equal access to quality health care facilities.

Table 6.2 summarises key gender and health indicators that will be referred to in greater depth throughout the chapter.

Table 6.1: SGDI and CSC scores on health

<table>
<thead>
<tr>
<th>Indicator</th>
<th>SGDI</th>
<th>CSC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scores</td>
<td>64%</td>
<td>81%</td>
</tr>
<tr>
<td>Ranks</td>
<td>11</td>
<td>2</td>
</tr>
</tbody>
</table>

Table 6.2: Key sexual, reproductive and health indicators

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Country statistic/policy</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current maternal mortality rate (deaths per 100 000 live births)</td>
<td>145</td>
<td>Although this is high by global standards, it is one of the lowest rates in the SADC region and second place after Mauritius. Studies have found that prevalence of HIV plays a significant role in the high Maternal Mortality Ratio (MMR) of the region.¹</td>
</tr>
<tr>
<td>% Births attended by Skilled Personnel</td>
<td>90</td>
<td>This is the fourth highest in the region - Seychelles, Mauritius and Botswana rank higher.</td>
</tr>
<tr>
<td>% Contraceptive use among sexually active women</td>
<td>60</td>
<td>This is the second highest in the region after Mauritius.</td>
</tr>
<tr>
<td>Country policy on abortion</td>
<td>Legal and women can choose to terminate pregnancy</td>
<td>South Africa is the only country in the SADC region where choice of termination of pregnancy is fully legal.</td>
</tr>
<tr>
<td>% Total coverage of sanitation facilities</td>
<td>74</td>
<td>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.</td>
</tr>
<tr>
<td>% Urban coverage</td>
<td>82</td>
<td>This is relatively high for the region, but pressure mounts as domestic migration from rural to urban areas increases.</td>
</tr>
<tr>
<td>% Rural coverage</td>
<td>62</td>
<td>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 20%.</td>
</tr>
</tbody>
</table>

¹ The Lancet, volume 375 No.9730 (www.TheLancet.com)
Maternal mortality ratio

The Maternal Mortality Ratio (MMR) 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. Stakeholders have focused global and continent-wide attention on reducing the MMR (which is also a Millennium Development Goal - number five), and this ratio has recently decreased in eight SADC member states (Angola, Madagascar, Mauritius, Mozambique, Namibia, South Africa, Swaziland and Tanzania). Increased access to HIV treatment and care is beginning to reverse the trend, but the rate of decrease remains too slow to meet the goals of either the Gender Protocol or the MDGs by 2015. Member states will have to put in a much greater effort in order to meet these targets.

South Africa has implemented a constitutional framework that endorses the right to health for the population. Legislators also put in place a number of policies and programmes aimed at improving maternal health in South Africa since 1994. In addition, South Africa is a signatory to a wide range of treaties and conventions that promote maternal health. However, gender activists cannot ascertain the benefits forthcoming from these initiatives at present, but hope they may bear fruit in coming years.

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 145 per 100 000, the maternal mortality rate in South Africa is among the lowest in the region. It is also down from 176 in 2013.

Maternal mortality and morbidity exacts a heavy cost on society: The consequences of maternal mortality and morbidity resonate not only with the families of women who die, but also with their communities and nations. If a woman dies in pregnancy or childbirth, the baby is much less likely to survive. It also 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.

2 MMR definition.
4 South Africa MDG report 2013.
Foetal alcohol syndrome is ravaging Western Cape farming communities, with hundreds of children affected, research has found.

That is according to the preliminary findings of a five-year study, currently in its fourth year, being conducted by UCT, Stellenbosch University, the University of New Mexico in the US, and the Medical Research Council of South Africa (MRC). The areas studied include Wellington, Bonnievale, Robertson, Ashton and Montagu.

According to the findings, the Western Cape still has the highest incidence of foetal alcohol syndrome worldwide.

The syndrome, which results from pregnant women drinking alcohol, is characterised in children by distinctive facial features, which include narrow-set eyes, a small head, small jaw, and a flattened groove between the nose and upper lip.

Alcohol intake during pregnancy can negatively affect the child’s central nervous system and coordination, mental and social development, as well as their ability to reason.

In Wellington, researchers found a prevalence of foetal alcohol syndrome of between 61 and 94 per 1 000 children. Researchers found the rate in the combined areas to be between 94 and 130 per 1 000 children. A total 1 663 children from Wellington took part in the study, while researchers assessed 3 319 from the combined areas.

The provincial government’s Robert MacDonald said the long-term results of foetal alcohol syndrome could be difficult to manage. “We’re under no illusion about the scale of the problem,” he said, adding that the challenge is to change people’s behaviour and to find skilled social workers to work in rural areas. Awareness campaigns alone would not solve the problem, he said, and this is the weakness in the government’s response, which relies on awareness.

Professor Phil May, of the University of New Mexico, said that if researchers diagnose children early and provide them with special education and opportunities, they could develop fairly well.

Another aspect of the research included community surveys, and the team found that a high percentage of the drinkers involved in the study exhibited symptoms of “hazardous” or harmful drinking.

Professor Charles Parry, director of the MRC’s drug and alcohol research unit, said 34% of the women surveyed in Wellington are drinkers, and 38% for the entire area. The researchers found that having 5.7 drinks twice a week in the first and second trimesters of pregnancy could result in a baby with foetal alcohol syndrome. A control group showed that 3.8 drinks twice a week could end in a normal birth.

The group tested 1 036 babies at six weeks of age, again at nine months, and at 18 months. The aim is targeted developmental education and special programmes for enhancing each child’s abilities.

Interventions for high-risk women included motivational interviewing and community reinforcement, where the team introduced the prospect of a more rewarding sober lifestyle. Researchers also recruited high-risk women from antenatal clinics in Wellington who study officers then worked with.

Article by Esther Lewis in the Cape Argus, Online publication, http://www.iol.co.za/capeargus/foetal-alcohol-syndrome-is-on-the-rise-says-study-1.1149361#.VEjivU0cTFM

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 include 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. Researchers found women who have access to health services more likely to have at least one of the recommended four antenatal visits, to deliver with a skilled health assistant, and to
have follow-up or post-natal care for themselves and their infants. Research has found that access to at least four antenatal care visits has 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 inter-sectoral partners linked to the delivery of identified outputs as they relate to a particular sector of government.5

The government agreed on 12 key outcomes as the key indicators for its programme of action for the period 2010-2014. It linked each outcome area to a number of outputs that inform the priority implementation activities that it undertook over the given timeframe to achieve the outcomes associated with a particular output. The Department of Health implemented a number of extensive policy initiatives aimed at reducing maternal mortality and improving the quality of health care throughout the health care system.6

**Health assessment**

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 rate their health status as good, followed by about a third who rate their health status as very good. However, a larger proportion of men than women rate their health as either good or very good, while women more often rate their health as fair or poor.

<table>
<thead>
<tr>
<th>Figure 6.2: Health self-assessment, 2008 and 2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very good</td>
</tr>
<tr>
<td>Female</td>
</tr>
<tr>
<td>Female</td>
</tr>
<tr>
<td>Male</td>
</tr>
</tbody>
</table>


**Visits to health workers**

Figure 6.3 illustrates that among both women and men, white people visit health workers more often. Meanwhile, black African people visit health workers least often. Across all four population groups, more women (8.2% for all groups combined) visit health care workers than men (6.2%). Researchers expect this pattern because in addition to other health care-related needs, women tend to have more needs, including for reproductive health and health care related to pregnancy and childbearing.

**Figure 6.3: Visits to a health worker during the month prior to the interview, 2011**

<table>
<thead>
<tr>
<th>Population Group</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black African</td>
<td>7.6</td>
<td>5.8</td>
</tr>
<tr>
<td>Coloured</td>
<td>9.6</td>
<td>7.2</td>
</tr>
<tr>
<td>Indian/Asian</td>
<td>9.6</td>
<td>6.4</td>
</tr>
<tr>
<td>White</td>
<td>12.1</td>
<td>9.5</td>
</tr>
<tr>
<td>Total</td>
<td>8.2</td>
<td>6.2</td>
</tr>
</tbody>
</table>

Source: GHS 2011.

Figure 6.4 reveals that, among those using health facilities in the month before the interview, research found white women (84%) and men (82.6%) most likely to use private health facilities. Indian/Asian women (61.4%) and men (61.3%) follow this. In contrast, among black African women and men who used health facilities in the month prior to the 2008 survey, only 32.3% accessed private health facilities.

Researchers found only a small difference between the percentage of women and the percentage of men who use private health facilities in each population group. Overall, the survey found South African men (39.9%) slightly more likely than women (38.8%) to visit private health facilities when they need health care.

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6 Ibid.
Figure 6.5 shows that in both 2002 and 2011, researchers found white women and men far more likely than other population groups to have access to medical aid benefits. In 2011, men’s 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 remained negligible within each population group. Access to medical aid benefits appears to have increased between 2002 and 2011 in all four groups, and for both women and men.

Access to skilled health professionals

Increasing the percentage of births that skilled health professionals attend results in a decrease in maternal mortality rates.

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. At 90%, South Africa ranks fourth in the SADC region for births attended by a skilled health professional. Four countries have more than 90% of births attended by a skilled health professional while five have fewer than 60%.

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 stakeholders had previously treated sexual and reproductive health 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, paragraph 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, professionals in this field have used the terms sexual and reproductive rights 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 stakeholders had 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.

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

Women - globally and in Southern Africa - suffer from lack of control over their own sexuality. 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 that 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. Largely 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, society often blames women for spread of disease, seeing them as the “vector,” even though a partner or husband infects the majority of women.

Violence against women has serious consequences for physical and mental health: research has found abused women 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; and various gynaecological problems including chronic pelvic pain and painful intercourse. Consequences such as HIV and AIDS or unplanned pregnancies may act as risk factors for further aggression, forming a cycle of abuse. Effects of violence may also be fatal because of intentional homicide, severe injury or suicide.

South Africa’s 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). Stakeholders intend this to maximise resource utilisation 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 Millennium (and post-2015) Development Goals, and addressing sexual and reproductive health and rights of adolescents and youth is a key part of the strategy.

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7 ICPD 1999.
8 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
Figure 6.7 shows that, at 60%, South Africa has the second highest level of contraceptive usage in Southern Africa. Five member states have contraceptive usage of more than 50%. Mauritius leads the region at 76%, followed by South Africa, Zimbabwe at 59%, and Lesotho and Swaziland at 56% and 51% respectively. The DRC and Angola have the lowest usage at 5% and 6%. The United Nations Population Fund (UNFPA) has estimated that these countries could prevent a third of maternal deaths if all women have access to contraceptive. Stakeholders need to invest more effort in this area.

Condoms

In South Africa, staff in the health system freely distribute the male condom. Civil society and the private sector also use their own platforms and spaces to distribute and provide alternative access points to the male condoms distributed by the Department of Health.

There have been campaigns to distribute female condoms but many complain that the female condom is not as easy to use as the male condom. This suggests that there might be more uptake of the female condom if stakeholders couple its distribution with better education on how to make use of it. In addition, it is more costly than male condoms.

In general, there is less knowledge on how to use female condoms and less awareness of their existence. Unlike male condoms, it is rare to find them distributed free of charge (this usually only happens at health centres).

It is important to note that access to condoms is just one piece of the puzzle. Increasingly, campaigns and initiatives deliberately target men to become actively involved in protected sex. Meanwhile, while South Africa does have the second highest contraceptive usage for the region (see Figure 6.7), it still has enormous challenges. Attitudes, opinions and cultural norms will determine the extent to which South Africans use condoms and other forms of contraception. 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 her pregnancy, without the knowledge or consent of her parents or partner. In the 15 years since it has been in force, stakeholders have accomplished a lot in terms of implementing the provisions of the act.

By the end of 2012, 57% of designated facilities provided safe termination of pregnancy services, exceeding the target of 45%. This has resulted in a great increase of terminations of pregnancy in health facilities and a corresponding reduction of unsafe “back street” abor-
tions. While backstreet abortions still occur, the implementation of this act has resulted in eliminating most deaths of women resulting from them. However, stigma, discrimination and negative attitudes of providers still make access to safe termination of pregnancy difficult, especially for adolescents. Professionals at health services need to increase access to contraception to prevent unwanted pregnancies rather than using abortion as a means of contraception.

While this is not an issue provided for in the Protocol, women’s rights activists have increasingly been debating it throughout the SADC region. There remains great resistance to the issue across the region, with only South Africa (and to some extent Zambia) having legalised abortion. However, given that illegal abortion is one of the main reasons for high maternal mortality rates throughout the region - not to mention the fact that there continue to be many unplanned pregnancies - it is clear that there needs to be more dialogue about abortion in SADC.

Sexual diversity

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 illegal. A hotly contested issue in the negotiations around the creation of the Protocol, stakeholders in the end did not include sexual orientation in the document. However, South Africa has invalidated the prohibition against same-sex relationships.

Unlike other countries in the region, South Africa has legalised same-sex relationships and/or marriage. In addition, discrimination based on gender identity and sexual orientation is illegal in South Africa, which constitutionally protects the rights of Lesbian, Gay, Bisexual, Transgender, Intersex (LGBTI) people. Despite this, inadequate services, discrimination and health rights violations continue to obstruct LGBTI people’s access to healthcare.

Services addressing LGBTI-specific health concerns - as well as sexual and reproductive health information and prevention resources - remain almost completely lacking in public facilities, according to a study on LGBTI access to public healthcare in the Western Cape and Gauteng provinces of South Africa. Consequently, people in both provinces rely primarily on LGBTI-specific health services and information (usually relating to HIV prevention and management) provided by NGOs such as OUT LGBT Well-being. Meanwhile, only a handful of clinics provide services for gay men, while none exist for the provision of healthcare to lesbian women or gender non-conforming people. Only three health facilities in the country provide services for gender reassignment for transgender people, and due to limited resources, people can wait up to 20 years for the service.

Health care for the marginalised

OUT LGBT Well-being has been providing health services since 1994, when it started a telephone counselling and information line. In 1997, the organisation began doing HIV work, which has increased over the years, especially after it opened a clinic in 2007.

A significant project is OUT’s PRISM Project. This is an acronym for Prevention and Research Initiative for Sexual Minorities. The PRISM project formed part of a collaborative effort between the Schorer Foundation (based in the Netherlands) and 16 organisations in the global south (including Southern Africa, Central and South America). The project aims to increase the quantity and quality of HIV/STI prevention for men-who-have-sex-with-men (MSM) and women-who-have-sex-with-women (WSW).

Towards the end of 2007, OUT conducted a needs assessment on resourced and under-resourced lesbian women as well as resourced gay men. It identified three key areas for intervention:

- Erroneous risk perception;
- Internalised homo-negativity; and
- Negative peer norms.

Keeping these three key areas in mind OUT developed an intervention strategy to address the needs of lesbian women and gay men. This includes initiatives such as the OUT clinic in Pretoria, which offers the following services:

- General physical examinations;
- HIV counselling and testing;
- CD4/Viral load testing;
- Referral for Anti-Retroviral (ARV) treatment;
- STI screening and treatment;
- Provision of Post-Exposure Prophylaxis (PEP);
- Wellness adherence and referral; and
- General referral and follow-up.

10 Dr. Alexandra Muller, 2014, Access to health care for lesbian, gay, bisexual and transgender South Africans, School of Public Health and Family Medicine, University of Cape Town.

Women in prisons and refugee camps

The situation regarding United Nations High Commission for Refugees (UNHCR) “People of Concern” changed little in Southern Africa over the last several years. At the end of 2013, the SADC region remained home to about half a million “people of concern,” including 131 300 refugees, 272 400 asylum-seekers, 1 700 returnees, 68 000 Internally Displaced Persons and 24 000 others (mostly former Angolan refugees). Most of the refugees in Southern Africa continue to live in protracted situations, though the region saw an increase in new arrivals from the Democratic Republic of Congo (DRC), as well as from northeast Africa. From 2006 to 2011, South Africa had the highest number of asylum-seekers in the world, but the numbers declined by 42% in 2012, compared to 2011. South Africa had 778 600 new asylum applications between 2008 and 2012, with almost half a million hailing from Zimbabwe. Men often rape or force into sex work girls and women living in countries at risk of, in the midst of, or emerging from, armed conflict. Experts view both as high-risk situations for contracting HIV or becoming pregnant. The health facilities in refugee camps are generally poor, with few qualified nurses and supplies.

According to the World Health Organisation, refugee camp clinics should provide access to contraceptives, condoms and HIV tests - and there should be at least one nurse/midwife per 500 patients. A strategy for improving the sexual and reproductive health (SRH) services available to women and girls in refugee camps is to train refugee women and girls to offer counselling, peer education and home-based care. A particular consideration is to prioritise availability of youth-friendly SRH services for young women and girls who have been growing up in refugee camps with little parental supervision and immense responsibilities and pressures.

The provision of SRH services for women in prisons or refugee camps is limited: While researchers could find very little information on existing policies or programmes, qualitative research conducted by the Zimbabwean Women Writers with women in prisons indicates that the SRH needs of women in prison remain inadequately addressed. Access to basic reproductive health needs such as sanitary pads is limited. Equally, pregnant women or those who deliver in prison reportedly face stigma and discrimination from prison guards who afford them no additional care or services for their children - some of which women raise within the prisons. Women also report high incidences of sexual violence and rape in prison.

Sanitation

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 - and research has found that women remain particularly vulnerable to such diseases. Furthermore, women without proper hygiene and sanitary facilities find menstruation, pregnancy, and post-natal care more difficult, as well as caring for family and community members living with HIV. According to the World Health Organisation, providing clean drinking water, better sanitation and improving water resources management to reduce the incidence of water-borne diseases and cases of accidental drowning can avoid almost one tenth of all global deaths.

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13 Gatsinzi, 2011.
14 Ibid.
Ahead of the national government elections in 2014, riots about sanitation increased in South Africa due to a lack of dignified sanitation facilities in some of the provinces in the country. Water shortages have also become an area of concern. Political parties in the Western Cape lodged complaints with the South African Human Rights Commission (SAHRC) and the Cape High Court about this issue.

Figure 6.8 shows that South Africa (74%) comes third in the coverage of sanitation facilities after Seychelles (97%) and Mauritius (89%); however, it is important to note that this is a drop from 79% reported in 2013. Eight of the 15 SADC countries remain below 50%.

Sanitation in South Africa has been a major issue in recent protests about the lack of service delivery in the country. As in other health categories, South Africa lags behind Seychelles and Mauritius, but comes in ahead of most other countries in the region.

Figure 6.9 shows that 62% of South Africa’s rural population have access to sanitation facilities; these facilities can be formal or informal, such as mobile latrines. As in other health categories, South Africa lags behind Seychelles and Mauritius, but comes in ahead of most other countries in the region.
While South Africa boasts one of the cleanest water systems in the world, a lack of sanitation and access in the country’s rural communities means the threat of water borne disease remains pervasive. Increasingly, faecal matter has contaminated the Vaal River, the largest River in South Africa and a popular tourist destination, due to lack of proper sanitation facilities in the area.

Table 6.3 shows that the Western Cape, at 75.1%, has the highest percentage of the population with piped water within a dwelling, followed by Gauteng at 62.1%. Limpopo has the lowest access of piped water at 18.4%. More people in the Eastern Cape have no access to water than any other province, followed by KwaZulu-Natal and Limpopo, at 14.1% and 14% respectively.

While South Africa boasts one of the cleanest water systems in the world, a lack of sanitation and access in the country’s rural communities means the threat of water borne disease remains pervasive. Increasingly, faecal matter has contaminated the Vaal River, the largest River in South Africa and a popular tourist destination, due to lack of proper sanitation facilities in the area.

Access to water

The South African government has made steady progress in ensuring that South African citizens have access to water. According to the 2011 National Census, 91.2% of households in South Africa have access to piped water inside their own homes or yards, or from communal taps, while 8.8% (or about 4.5 million people) had absolutely no access to piped water.

Until recently, South Africa did not have issues accessing clean water. However, water is becoming scarcer thanks to increasing temperatures due to climate change, lack of infrastructure, and infrastructure that is no longer in working condition.
As the 2015 target date for achieving the Millennium Development Goals (MDGs) approaches, there is an ongoing debate as to what development goals the global community should set post-2015 in the health sector. The analysis in this chapter shows the feasibility of the current SADC Gender Protocol targets, but success will require concerted efforts to address health, including sexual and reproductive health and rights throughout the region. SADC lawmakers urgently need to address women’s lack of education, resources and power. They must recognise women’s distinct health needs and responsibilities, which should be integral to the formulation of legislation, policy and programmes throughout the region going forward.

Speaking at the Giyani Stadium in Limpopo following the launch of the Giyani Treatment Works in November 2014, South Africa’s president acknowledged that water is a problem in the country. He said several provinces face water shortages, noting that this exacerbates health and sanitation challenges. Women and girls experience a number of challenges when communities lack water and sanitation services. They have to walk longer distances to collect water and perform ablutions, leaving them with less time for other activities and vulnerable to sexual assault.

According to a report released by the South African Human Rights Commission (SAHRC), titled Right to Access Sufficient Water and Decent Sanitation in South Africa, “The state of access to water and sanitation in South Africa, particularly for the poorest people in outlying areas, needs to improve.

“The commission will hold government across all spheres and departments, accountable for upholding human rights,” stated the report, which found “appalling infrastructure failures and little or no access to water and sanitation” in rural communities in all nine provinces.

As the 2015 target date for achieving the MDGs approaches, there is an ongoing debate as to what development goals the global community should set post-2015 in the health sector. The analysis in this chapter shows the feasibility of the current SADC Gender Protocol targets, but success will require concerted efforts to address health, including sexual and reproductive health and rights throughout the region. SADC lawmakers urgently need to address women’s lack of education, resources and power. They must recognise women’s distinct health needs and responsibilities, which should be integral to the formulation of legislation, policy and programmes throughout the region going forward.
The current MDG framework narrowed women's health needs to only maternal health, HIV and AIDS. Stakeholders must put a greater emphasis on all aspects of women's health rights to ensure that the post-2015 framework makes provisions for access to sexual and reproductive healthcare. This must include better access to the right to termination of pregnancy as well as rights associated with contraceptive choice.

Below is a possible set of health indicators for the post-2015 framework. These derive based on existing targets of the SADC Gender Protocol, the Sustainable Development Goals (SDGs) and consultations in the run-up to the 2014 SADC Gender Protocol@Work summit. Indicators derive from existing targets in the SADC Gender and Development Index (SGDI), including those proposed for the SGDs and put forward by various advocacy groups.

### Table 6.4: Proposed revised targets and indicators for Health

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<tr>
<th>Area of concern</th>
<th>Proposed post-2015 targets</th>
<th>Proposed post-2015 indicators</th>
<th>Priority indicators</th>
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| Maternal mortality                      | By 2030, reduce the maternal mortality ratio to less than 70 maternal deaths per 100 000 live births (Draft SDG 3.1) | 1. Maternal mortality ratio (out of 100, 000)¹⁶  
2. Percentage of births attended by skilled personnel¹⁸  
3. Percentage ante-natal care coverage  
4. Percentage of men attending ante and post natal care facilities. | Reduction in the barriers to access to sexual and reproductive health services particularly for young people and the most marginalised.¹⁷ |
| Sexual and reproductive health rights   | By 2030 ensure universal access to sexual and reproductive health and reproductive rights in accordance with the Programme of Action of the ICPD and the Beijing Platform for Action (Draft SDG 5.6) | 5. Contraceptive prevalence rate¹⁹  
6. Reduction in the barriers to access to sexual and reproductive health services particularly for young people and the most marginalised.²⁰  
7. Proportion of local councils that provide diverse and inclusive information on health and sexual reproductive health rights. | Existence and provisions of country policy on termination of pregnancy. |
|                                         | Ensure people, especially adolescents are educated about their sexual and reproductive health and rights. |                               |                     |
|                                         | Adopt and implement laws ensuring women's sovereignty and choice over their bodies and reproductive health choice right to life. |                               |                     |
|                                         | By 2030, achieve universal access to safe and affordable drinking water for all (Draft SDG 6.1). |                               |                     |

¹⁵ Priority indicators were identified at the Post 2015 Roundtable discussion on 16 October, participants included the Department of Trade and Industry, SAWID, Women in the Presidency M and E unit, WDB Trust, Commission for Gender Equality, Sonke Gender Justice, Department of Cooperative Governance and Traditional Affairs.

¹⁶ WHO, Health Demographic surveys.

¹⁷ WHO Development Indicators.

¹⁸ WHO, Health Demographic surveys.

¹⁹ WHO Development Indicators.

²⁰ WHO Development Indicators.
The following comprise key recommendations and next steps to ensure that South Africa achieves the 2015 targets and continues to improve the health of the population:

- Focus more attention on health services and sanitation for rural and lower income populations.
- Address the disparities in provision of health services and sanitation between urban and rural as well as higher income and lower income populations.
- Involve women in health and sanitation programmes. 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. The South African government is signatory to international and regional instruments that advocate for better health services, government must report to the citizens.
- Distribute female condoms at no cost and ensure women across the country have access to them.
- Increase training programmes to increase awareness and ensure more campaigns target women and men and teach them how to use the female condom.
- Promote sexual and reproductive rights for all adolescents, men and women. Stakeholders can achieve this through integration of sexual and reproductive rights into school curricula from primary school level.
- Provide adolescent-friendly services, including family planning and access to safe abortions.
- Engage traditional leaders, as well local government, in the promotion of sexual and reproductive rights and services to all people, irrespective of sexual orientation, gender identity, mental status and abilities.
- Focus on people in vulnerable positions through the provision of sexual and reproductive health services for women and men in prisons and in refugee camps.