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‘I am at the lowest end of all’

Rural women living with HIV face human rights abuses in South Africa

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***Front cover*: Women on a long journey home after collecting food from church workers assisting orphans in rural KwaZulu-Natal province. © Reuters/Mike Hutchings**
***Back cover (top)*: Information pamphlet for rape survivors explaining their rights and how to protect their health. © CSVR & ALP**
***Back cover (bottom)*: Poster promoting community campaigns against gender-based violence, produced by the Department of Social Development. © Amnesty International**

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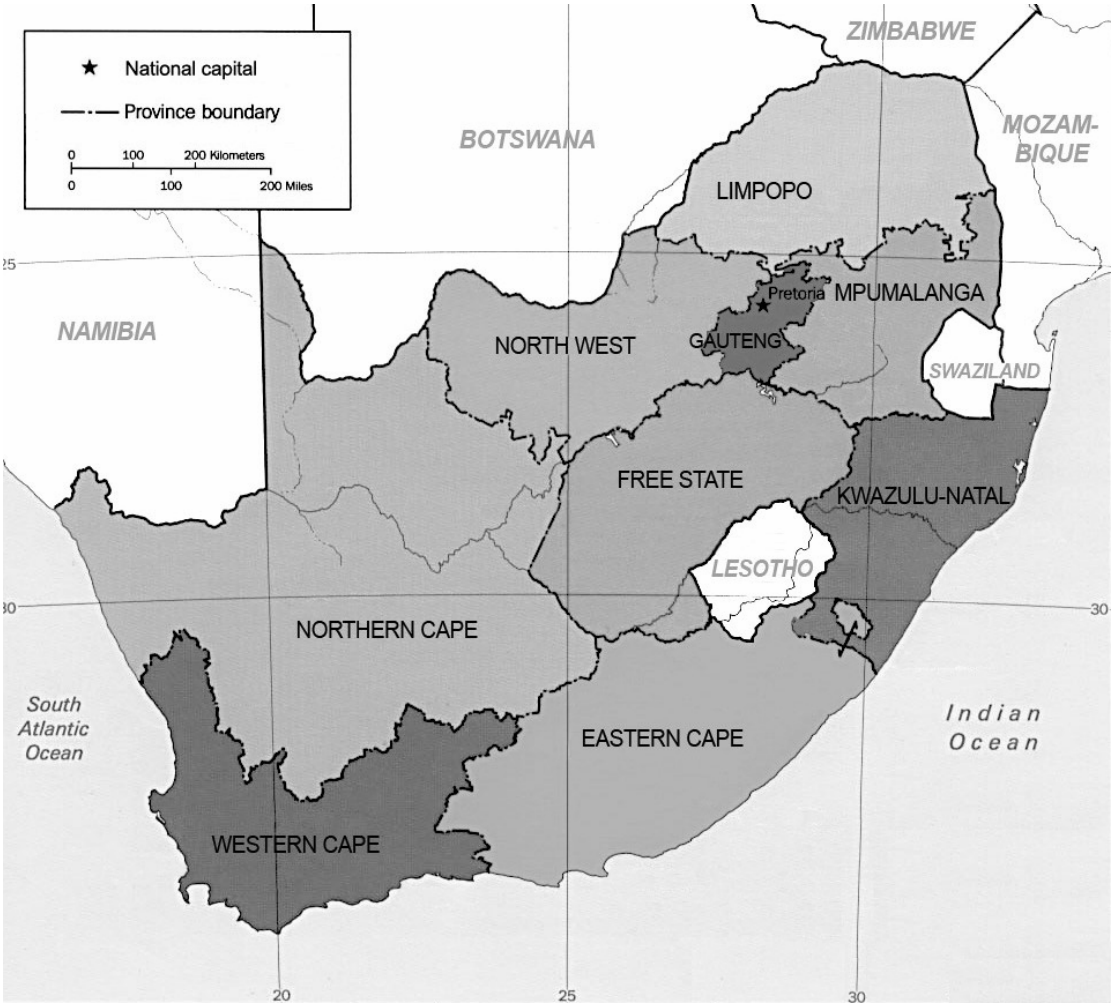

[1] Adapted by Amnesty International from a map by the University of Texas

Glossary of acronyms and terms

AI	Amnesty International
AIDS	Acquired immunodeficiency syndrome
ART	Antiretroviral therapy or medication
ARV	Antiretroviral [usually an adjective used to describe medication]
Assault GBH	Assault with intent to cause grievous bodily harm
CEDAW	(UN) Committee on the Elimination of all Forms of Discrimination against Women
CESCR	(UN) Committee on Economic, Social and Cultural Rights
CHC	Community Health Centre
DoH	Department of Health
DVA	Domestic Violence Act (No.116 of 1998)
FCS	Family Violence, Child Protection and Sexual Offences Unit
HIV	Human immunodeficiency virus
HRW	Human Rights Watch
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic, Social and Cultural Rights
NDoH	National Department of Health
NGO	Non-governmental organization
NSP	HIV & AIDS and STI Strategic Plan for South Africa, 2007-2011
PEP	Post-exposure prophylaxis
PHC	Primary health care (facilities)
PMTCT	Prevention of mother to child transmission (of HIV)
SAEC Kit	Sexual Assault Evidence Collection Kit
SANAC	South African National AIDS Council
SAPS	South African Police Service
SPO	Service-providing organization
SRH	Sexual and reproductive health
STI	Sexually transmitted infection
TB	Tuberculosis
UNGASS	UN General Assembly Special Session on HIV/AIDS
VCT	Voluntary counselling and testing

Organizations

ALP	AIDS Law Project
ARK	Absolute Return for Kids
CADRE	Centre for Aids Development, Research and Education
CASE	Community Agency for Social Enquiry
CIET	Community Information, Empowerment and Transparency
CSVR	Centre for the Study of Violence and Reconciliation
FEW	Forum for the Empowerment of Women
GRIP	Greater Nelspruit Rape Intervention Project
HSRC	Human Sciences Research Council
ICW	International Community of Women Living with HIV/AIDS
JCSMF	Joint Civil Society Monitoring Forum

MRC	Medical Research Council
MSF	Médecins Sans Frontières
NMF	Nelson Mandela Foundation
OSISA	Open Society Initiative for Southern Africa
PACSA	Pietermaritzburg Agency for Christian Social Awareness
POWA	People Opposing Women Abuse
PWN	Positive Women's Network
RADAR	Rural AIDS and Development Action Research
RAPCAN	Resources Aimed at the Prevention of Child Abuse and Neglect
SAHRC	South African Human Rights Commission
SAMA	South African Medical Association
SANAC	South African National AIDS Council
SWEAT	Sex Worker Education and Advocacy Task Force
TAC	Treatment Action Campaign
TLAC	Tshwaranang Legal Advocacy Centre
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
WHO	World Health Organization
WISER	Wits Institute for Social and Economic Research

'I am at the lowest end of all' Rural women living with HIV face human rights abuses in South Africa

Preface

In South Africa in late 2006 a new spirit seemed to have taken hold in public discussions on how to achieve a more concerted, effective response to the country's epidemic of HIV infection. The ensuing collaborative efforts, which drew in health department officials, civil society organizations and medical specialists, resulted eventually in agreement on a number of issues: notably that the challenges posed by persistent poverty as well as violence and other forms of discrimination against women had to be addressed as part of an effective overall response to the epidemic and the realization of the right to health of those affected and infected by HIV. The consensus on this and other issues was reflected in a new plan adopted by Cabinet in May 2007 to guide the work of the next five years.[2]

This report, which reflects research undertaken by Amnesty International (AI) in 2006 and 2007, provides an analysis of patterns of human rights abuses against women who are exposed to the risk of or are already living with HIV in rural contexts of widespread poverty and unemployment. It draws on the testimonies of 37 women who, to varying extents, had experienced incidents of violence from intimate partners or strangers, were unable to secure a stable income, faced periods of hunger, but were striving to maintain their access to health services and adhere to treatment despite the consequences of poverty, stigma and their low social status.

The women involved were interviewed by AI in Mpumalanga and KwaZulu Natal provinces, in collaboration with local service providing organisations with whom AI has worked for some years. The interviews were conducted with the assistance of interpreters in most cases and the support of the organizations' lay-counsellors. The interviewees' identities have been protected throughout this report to ensure their right to privacy and to avoid any possible harmful consequences resulting from their identification. Identifying place names have also been excluded when referring to their testimonies.

While there were singular aspects to each of their stories, some common themes emerged which pointed towards wider, more systemic factors which affected the women's ability to realize their right to health. In the following chapters some of these factors are examined, including the direct and indirect impact of gender-based violence, discriminatory attitudes and gender stereotypes, and economic marginalisation. In attempting to assess their effects, AI has drawn on information provided to it in meetings and other communications with non-governmental and government sector service providers, human rights and advocacy

[2] The HIV & AIDS and STI Strategic Plan for South Africa, 2007 – 2011 (NSP). Pretoria, 2007. Available at: http://data.unaids.org/pub/ExternalDocument/2007/20070604_sa_nsp_final_en.pdf

Some of South Africa's international human rights treaty commitments

Along with the majority of countries in the world, the government of South Africa has signalled its commitment to human rights by signing, ratifying or acceding to a number of international treaties embodying important human rights principles (set out below). One of the measures of a government's human rights performance is the extent to which it meets the international commitments it has voluntarily entered into. Governments should also be guided by the recommendations contained in inter-governmental declarations such as the UN Declaration on the Elimination of Violence against Women and UNGASS (2001), as well as general comments of the monitoring committees of the treaties which they have ratified.

Treaty[3]	Signed	Ratified (R) / Acceded to (A)
International Covenant on Civil and Political Rights (ICCPR)	3 October 1994	10 December 1998 R
Optional Protocol to the ICCPR permitting submission of individual complaints		28 August 2002 A
International Covenant on Economic, Social and Cultural Rights (ICESCR)	3 October 1994	Not ratified, but has signalled intention to ratify[4]
Convention on the Elimination of all Forms of Discrimination against Women (Women's Convention)	29 January 1993	15 December 1995 R
Optional Protocol to the Convention on the Elimination of all Forms of Discrimination against Women permitting submission of individual complaints		18 October 2005 A
International Convention on the Elimination of All Forms of Racial Discrimination (CERD)		9 January 1999
Convention on the Rights of the Child	29 January 1993	16 June 1995 R
Convention against Torture and Other Forms of Cruel, Inhuman and Degrading Treatment or Punishment	29 January 1993	10 December 1998 R
Optional Protocol to the Convention Against Torture	20 September 2006	
African Charter on Human and Peoples' Rights (African Charter)	9 July 1996	9 July 1996 R
Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Protocol to the African Charter on the Rights of Women in Africa)	16 March 2004	17 December 2004 R
African Charter on the Rights and Welfare of the Child	10 October 1997	7 January 2000 R

[3] Treaties referred to in the report use the bracketed abbreviations for ease of reference.

[4] When presenting its candidature for re-election to the UN Human Rights Council for the period 2007-2010, the South African government informed the UN General Assembly that it was in the process of ratifying several "important human rights instruments", including the International Covenant on Economic, Social and Cultural Rights. Note verbale dated 26 April 2007 from the Permanent Mission of South Africa to the United Nations addressed to the President of the General Assembly. UN GA, A/61/889, 1 May 2007.

organizations, policy development and research institutions, health professionals and government officials. The report's analysis has also benefited from some of the extensive published research undertaken by South African and international organizations. Finally, the report's analysis and conclusions are underpinned by a framework of human rights standards which reflect the consensus of the international community. South Africa since 1994 has participated in the further development of these standards, as well as shown its acceptance of them through its commitments made under key international human rights treaties. This report and associated campaign are intended as contributions towards South African efforts to overcome the legacies of the past and address current human rights abuses.

Introduction

HIV and AIDS in South Africa

South Africa is continuing to experience a severe HIV epidemic.[5] Five and a half million South Africans are HIV-infected, the highest number of people in any one country in the world. Fifty-five per cent of them are women.[6] UNAIDS estimated that 320,000 people died of AIDS in 2006.[7] The epidemic developed rapidly from the first case recorded in 1982,[8] to a national prevalence rate of at least 16 per cent in 2005.

The epidemic had begun during a period of extreme state violence and political and racial oppression which included government imposed states of emergency from 1985 to 1990, and continued to develop while the country was largely preoccupied with the efforts to negotiate the end of the apartheid system and National Party rule and securing the transition to non-racial democracy in 1994. Initially perceived in South Africa as a disease particularly affecting gay men and people receiving blood transfusions, it became apparent that HIV and AIDS was not confined to particular 'at-risk' groups but was becoming a generalised epidemic in certain communities.[9] From 1991 onwards the majority of transmissions in South Africa were through heterosexual intercourse. In 1993 the national prevalence rate amongst pregnant women attending antenatal clinics was 4.0 per cent; in 1996 it was 14.2 per cent; and by 1999 22.4 per cent of pregnant women attending antenatal clinics were HIV-infected.[10] In

[5] HIV or human immunodeficiency virus was identified in 1984 as the cause of AIDS (acquired immunodeficiency syndrome). The virus grows in particular white cells in the blood – known as CD4+ T lymphocytes – which are essential to the body's immune response. It eventually damages or kills these cells releasing further viruses to continue the spread of the infection in the body. Eventually the infected person's body becomes unable to fight infections and certain cancers; they become liable to infection with other viruses, bacteria or yeast which do not normally harm people – the so-called opportunistic infections. As the number of CD4+ T-lymphocytes decreases, the risk and severity of opportunistic infections increase. A person has AIDS when they have one or more of the over 20 most common opportunistic infections that define AIDS or if their CD4+ cell count is below 200. The most common methods of transmission involve exposure to blood, semen or breast milk.

[6] NSP(2007) pp.22,24,28. At p.24 (Table 1: HIV and AIDS Indicators at mid-2006) the NSP refers to the number of adult women (20-64) living with HIV/AIDS as 2,702,000, which is 55.40 per cent of the estimated total adult infected and 50.30 per cent of the estimated total HIV infected.

[7] http://www.unaids.org/en/Regions_Countries/Countries/south_africa.asp. Accessed 31 May 2007.

[8] Abdool Karim Q, Abdool Karim SS (2002).

[9] Cameron (2005), pp. 78-81; Schneider H, Stein J (2000).

[10] Barnett T, Whiteside A (2002), pp. 17 (Fig. 1.2), 118-119 (Table 4.7 and Fig 4.5); NSP, p. 21 (Fig 1).

2005 data from a population survey indicated that 16.2 per cent of adults 15 to 49 years were infected, while UNAIDS, using antenatal clinic data, published an estimate of 18.8 per cent prevalence for adults 15 to 49 years of age.[11]

This desperate situation was unfolding while the country from 1994 was engaged in remarkable legal and institutional transformations which began to affect every sphere of life. These changes included the finalisation and adoption in 1996 of a constitution with a legally enforceable bill of rights protecting, among others, the right to equality, to bodily and psychological integrity, to freedom from violence from either public or private sources, and to the realization of the right to health without discrimination on any grounds. Within this framework institutional reforms were initiated, for instance, to improve access to education and to employment for "historically disadvantaged groups", to integrate and reform the health services,[12] as well as the policing and criminal justice systems with the intention to improve service delivery for all South Africans without discrimination.

Despite the relentless upward trend in HIV infection rates, the government's initial responses to the epidemic were slow and erratic during the Mandela presidency.[13] From late 1999 the government of President Thabo Mbeki took a direction which turned a public health emergency into a matter of political conflict. For whatever complex reasons, President Mbeki's decision publicly to question the link between the virus and the onset of AIDS, as well as the efficacy and safety of the then known drug treatments, precipitated a period of confusion and demoralisation within government departments and the public health services and disputes between national and some provincial governments over responses to the epidemic. Adding to these consequences was a growing bitter conflict with sectors of civil society, including medical practitioners, who were pressing for access to antiretroviral treatment for HIV-infected pregnant women and others with AIDS. There was a loss of strong unified leadership at a critical juncture in the life of the epidemic and a further delay in access to life-saving medicines for those with AIDS who were dependent on the public sector for health services.[14]

In late 2001 the Treatment Action Campaign (TAC)[15] obtained an order in the Pretoria High Court requiring the government to supply antiretroviral medication to pregnant women

[11] Data from a population survey suggested that the prevalence in 2005 was at 16.2% in adults 15 to 49 years of age (Shisana O et al (2005)); the UNAIDS figures were based on 2005 antenatal clinic survey data (see UNAIDS (2006)). See also NSP (2007), pp.7, 22, noting that "In 2005 about 5.4 million people were estimated to be living with HIV in South Africa, with 18.8 % of the adult population (15-49 years)".

[12] See National Health Act No.61 of 2003, which came into force in July 2004, which aims to establish the national health system on a basis to "provide in an equitable manner the population of the Republic with the best possible health services that available resources can afford" in compliance with the provisions of the 1996 Constitution. Under the constitutional arrangements and in terms of Chapter 4 of Act 61, governments in the nine provinces have authority to set their own budgetary priorities, but in the context of "national health policy, norms and standards".

[13] Cameron E (2005), pp. 123-126; Natrass N (2004), pp.41-48.

[14] Cameron E (2005), pp.103- 122,126,136-149; Fassin D (2007), pp.30 -168; Gumede, W (2007), pp. 187-215; Natrass N (2004), pp.48-65.

[15] TAC was established on 10 December 1998 in Cape Town to campaign for access to antiretroviral medication for all those in need. See: http://www.tac.org.za. Many global policy developments in the area of HIV and AIDS responses have taken their cue from the leadership provided by South African civil society. In particular, strategies and campaigning approaches developed in South Africa, including an assertive human rights framework for the prevention of and response to HIV and AIDS, have been adapted to push issues affecting people living with HIV globally.

to prevent transmission of the virus to their babies. The High Court ruling was confirmed by the Constitutional Court in July 2002 after the Department of Health appealed the High Court decision.[16] The Constitutional Court held that "Sections 27(1) and (2) of the Constitution require the government to devise and implement within its available resources a comprehensive and co-ordinated programme to realize progressively the rights of pregnant women and their newborn children to have access to health services to combat mother-to-child transmission of HIV".

In November 2003 the Minister of Health, Dr Manto Tshabalala-Msimang, announced the government's decision to provide antiretroviral treatment in the public health sector within the framework of the National Operational Plan for Comprehensive HIV and AIDS Management, Treatment, Care and Support (NOP). Antiretroviral therapy (ART) finally and slowly began to be provided in public sector hospitals from 2004.[17] The "roll-out" of treatment occurred at a pace below the targets indicated in the NOP and was dogged by an atmosphere of distrust of government intentions. Advocacy groups observed that the Cabinet-approved NOP had "committed the state in 2003 to placing approximately 645,740 people on ARV treatment in the public sector by the end of 2006/7 financial year,"[18] but according to Department of Health information, "approximately 250,000 people had been initiated on ARV treatment in the public health sector by this time."[19] By mid-2006, 200,000 adults were on treatment while an estimated 511,000 still needed to begin ART.[20] The numbers had risen to 303,788 patients on treatment by May 2007, according to the government's MDGs Mid-Term report, and to 408, 218 by the following November.[21]

The tensions between government and civil society over responses to the HIV epidemic appeared to reach a nadir at the XVI International AIDS Conference in Toronto in August 2006. The promotion by the Minister of Health at the conference of a diet-based treatment for AIDS led to further national and international pressure and criticism of the government. [22] The Deputy President, Phumzile Mlambo-Ngcuka, as Chairperson of the reconstituted South African National AIDS Council (SANAC), began to have an increasingly prominent role in the oversight of the response to the epidemic and the development of the new national strategic plan.[23] As described in the NSP which was adopted by SANAC in April 2007 and

[16] Judgment in Minister of Health and Others, Appellants Versus Treatment Action Campaign and Others, Respondents, Constitutional Court , Case CCT 08/02, 5 July 2002, at para. 135 (available at: http://www.constitutionalcourt.org.za/).
[17] ART was already available for people using the private health sector, through some employer–provided schemes and through initiatives such as the clinic established by MSF and the Department of Health of the Western Cape in Khayelitsha in 2001.
[18] That is, 31 March 2007.
[19] ALP, the National Education, Health and Allied Workers Union (NEHAWU) and TAC (2007), at para.3.3.
[20] NSP (2007), p. 25 (Table 1: HIV and AIDS Indicators at mid-2006), which notes that 511,000 adults who were at stage IV of the disease were not on treatment. With children below 14 years the gap was narrower, with 27,000 at stage IV but not on treatment and 25,300 receiving treatment. The WHO in 2002 had recommended that all people at stage IV of HIV disease (clinical AIDS) should be on ART, as well as those at earlier stages whose CD4 T Cell (CD4) count is below 200. See WHO (2002). The treatment threshold was subsequently raised to 350 (see Department of Health and Human Services Panel on Antiretroviral Guidelines for Adults and Adolescents. *Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents, December 1, 2007*. Available at: http://aidsinfo.nih.gov/contentfiles/AdultandAdolescentGL.pdf.)
[21] South African Government, Millenium Development Goals Mid-Term Report, September 2007. The November total appears to be revised official totals, according to the ALP (personal communication to AI, 29 February 2008).
[22] Kapp C (2006).
[23] NSP (2007), p.7.

the Cabinet in the following month, the final version of the plan had been developed through an intensive and consultative process over a six month period.[24] SANAC symbolised the changes with its membership and co-chairing role for civil society.[25] The process of developing the new NSP was described to AI as genuinely participatory by civil society organizations.[26] As summarised by the Joint Civil Society Monitoring Forum, the new plan proposed to expand the access to appropriate treatment, care and support to 80 per cent of all HIV positive individuals by 2011; create a social environment which encouraged HIV testing, and promote, protect and monitor human rights involved in these interventions.

Some uncertainties still remained, however, when in August 2007 the goodwill developed during this process was put at risk by the dismissal by President Mbeki of the Deputy Minister of Health, Nozizwe Madlala-Routledge, after she participated in an AIDS conference in Spain without his formal approval.[27] The Deputy Minister had been an active participant in the development of the NSP. In a further sign of unresolved issues, public controversy intensified in late 2007 over the delays in producing new guidelines and budget for the provision of dual therapy treatment to pregnant women prior to labour and to their new born babies to prevent HIV transmission, consistent with revised WHO guidelines and in compliance with the ruling of the Constitutional Court in 2002. Approval of the new guidelines appeared imminent in September, but they had still not been produced by the following February. While the Western Cape Province had implemented since 2004 the dual therapy regime and had reduced infant infection rates reportedly to less than 10 per cent, other provinces continued to use single therapy treatment while awaiting national authorisation. The Southern African HIV Clinicians Society expressed concern that children were continuing to be infected unnecessarily. In KwaZulu Natal Province, a hospital doctor, who in 2007 had raised concerns with the Department of Health about the delays, was charged in February with misconduct for accepting outside funds to implement dual therapy at his hospital. Although the departmental charge was later dropped, the incident and associated public outcry indicated that the new spirit of collaboration which had helped create the NSP was still fragile.[28]

[24] NSP (2007), pp.52-53. See also JCSMF, "South Africa's National HIV Strategy (2007-2011): An Opportunity for Health Equity, an Embodiment of Health Rights", 28 June 2007 (Available at: http://www.jcsmf.org.za/?q=node/114/).

[25] See: ALP. News: SANAC adopts the HIV & AIDS and STI Strategic Plan for South Africa 2007 – 2011 (Available at: http://www.alp.org.za). AI interview with Dr Rachel Jewkes, Medical Research Council, Pretoria, 14 May 2007.

[26] Symptomatic of this thaw between former antagonists was the holding of a "dialogue" in September 2006, hosted by the NMF and MSF. National and provincial department of health officials, international and local NGO health rights activists, and health care professionals shared lessons on models of delivery of ART in "resource-limited settings" and with marginalised populations, with a view to contributing to national policy development and effective, non-discriminatory access to ART (NMF and MSF (2006)); AI interview with Dr Mothomang Diaho, NMF, Johannesburg, 31 October 2006).

[27] In an open letter to the Deputy President, representatives of churches, NGOs, trade unions, and HIV advocates alluded to the treatment of Ms Madlala-Routledge and called on the Deputy President "to restore our confidence in government's commitment to the NSP". See Open letter to Ms. Phumzile Mlambo-Ngcuka, 21 August 2007, available at: http://www.tac.org.za/documents/OpenLetterToDeputyPresident.pdf

[28] *Manto's statements slammed* (News24.com, Johannesburg, 14 September 2007); *South Africa: New PMTCT Protocol in Two Weeks* (Health-e, Cape Town, 30 November 2007); *South Africa: Revised PMTCT Guidelines by Friday* (Health-e, Cape Town, 23 January 2008); *South Africa: Enough delays on PMTCT – Doctors* (Health-e, Cape Town 23 January 2008); *Media Statement*, Department of Health KwaZulu Natal, 11 February 2008. *KZN doctor cleared on treatment charge* (Mail&Guardian 21 February 2008). See also WHO (2006). *Antiretroviral drugs for treating pregnant women and preventing HIV infection in infants: towards universal access: recommendations for public health approach – 2006 version.* Geneva: WHO, tables 5 and 6. (Available at: http://www.who.int/hiv/pub/guidelines/pmtctguidelines3.pdf .

Realizing the Right to Health

In the words of the Special Rapporteur on the right to health, "at the heart of the right to the highest attainable standard of health lies an effective and integrated health system, encompassing health care and the underlying determinants of health, responsive to national and local priorities, and accessible to all."[29] A number of international treaties make reference to health-associated rights. The ICESCR states at Article 12 that "*Everyone has the right to the highest attainable standard of physical and mental health*".[30] The CESCR has provided an interpretation of the meaning of this right in General Comment 14.[31] In this comment the CESCR notes that "the right to health contains both freedoms and entitlements. The freedoms include the right to control one's health and body, including sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and experimentation. By contrast, the entitlements include the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health." [para.8] The Comment asserts that the "right to health in all its forms and at all levels contains the following interrelated and essential elements": health care should be *available*, *accessible* (including being affordable), *acceptable* and of good *quality*. [para.12]

Meeting the terms of Article 12 "requires the establishment of prevention and education programmes for behaviour-related health concerns such as [STIs], in particular HIV and AIDS, and those adversely affecting sexual and reproductive health, and the promotion of social determinants of good health, such as environmental safety, education, economic development and gender equity" [para.16]. The Women's Convention at Article 12 states: "States Parties shall 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."[32] CEDAW, in General Recommendation 15, urged that "programmes to combat AIDS should give special attention to the rights and needs of women and children, and to the factors relating to the reproductive role of women and their subordinate position in some societies which make them especially vulnerable to HIV infection".[33] The UN Special Rapporteur on the right to health has published numerous reports contributing to the understanding of the right to health.[34] In a foreword to the International Guidelines on HIV/AIDS and Human Rights the UN High Commissioner for Human Rights and the Executive Director of UNAIDS draw attention to the fact that "the content of the right to health has been increasingly defined and now explicitly includes the availability and accessibility of HIV prevention, treatment, care and support for children and adults".[35]

Under Section 27(2) of the South African Constitution, the State "must take reasonable legislative and other measures within its available resources, to achieve the progressive realisation" of a number of rights, including "the right to have access to…health care services, including reproductive health care" (Section 27(1)(a).

[29] Human Rights Council, seventh session, Agenda Item 3. Promotion and Protection of all human rights, civil, political, economic, social and cultural rights. Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt. A/HRC/7/11. 31 January 2008.
[30] International Covenant on Economic, Social and Cultural Rights. Available at: http://www.ohchr.org/english/law/cescr.htm.
[31] Committee on Economic, Social and Cultural Rights. General Comment 14. http://www.unhchr.ch/tbs/doc.nsf/(symbol)/E.C.12.2000.4.En.
[32] Convention on the Elimination of All Forms of Discrimination against Women. Available at: http://www.un.org/womenwatch/daw/cedaw/.
[33] Committee on the Elimination of Discrimination against Women (CEDAW Committee). General Recommendation 15. Available at: http://www.un.org/womenwatch/daw/cedaw/recommendations/recomm.htm.
[34] The Special Rapporteur's reports are available at: http://www.unhchr.ch/html/menu2/7/b/mhealth.htm or http://www.ohchr.org/english/issues/health/right/index.htm
[35] Office of the UN High Commissioner for Human Rights, Joint UN Programme on HIV/AIDS (2006), p.6.

The female face of the HIV epidemic: the impact of discrimination, violence and poverty

> *"The HIV epidemic and AIDS* [in South Africa] *is clearly feminized, pointing to gender vulnerability that demands urgent attention as part of the broader women empowerment and protection. In view of the high prevalence and incidence of HIV amongst women, it is critical that their strong involvement in and benefiting from the HIV and AIDS response becomes a priority."* (NSP)[36]

Women are particularly affected by HIV and AIDS. As noted by the Executive Director of UNAIDS in his opening address at the July 2007 International Women's Summit, "…the most significant development of the AIDS epidemic is its growing feminization. What entered history 25 years ago as a disease of white gay men is now increasingly affecting women all over the world."[37] Of the 40 million people living with HIV globally in 2007, almost half are women – reaching 60 per cent in sub-Saharan Africa.[38] In South Africa, women under 25 are three to four times more likely to be HIV-infected than men in the same age group.[39] Significantly, the level of new HIV infections amongst women in South Africa continues to increase, while overall incidence of the disease has levelled off.[40] Data presented to the Third South African AIDS Conference in June 2007 indicated that of the more than 500,000 new infections in 2005, the highest incidence occurred in young women aged 15 to 24 years.[41] Provincial antenatal clinic prevalence rates vary considerably, ranging from 15.7 per cent in the Western Cape to 39.1 per cent in KwaZulu Natal.[42]

The NSP notes that while the immediate determinants of the spread of HIV relates to behaviours such as unprotected sexual intercourse, multiple sexual partnerships, and some biological factors such as concurrent sexually transmitted infections (STIs), women's socio-economic disempowerment and the impact of gender-based violence contributed to women's significantly higher infection rates.[43] Women are biologically more vulnerable than men to contracting the virus through unprotected vaginal intercourse.[44] Available evidence globally,

[36] NSP (2007), p. 35.
[37] Piot P (2007). Dr Piot is also an Under Secretary-General of the United Nations.
[38] Global Coalition on Women and AIDS (2006), p.8.
[39] NSP (2007), p.22 (Fig. 2: National prevalence by age and sex:2005), p.28.
[40] NSP (2007), pp.22-23.
[41] Shisana O. The situation of the HIV and AIDS epidemic in South Africa: we can turn the tide. Presentation at the Third South African National AIDS Conference, 3-5 June 2007, Durban. (Available at: http://www.sa-aidsconference.com/Presentations/Shisana,Olive.pdf)
[42] NSP (2007), pp. 25, 26 (Fig.4: HIV prevalence of antenatal attendees by province: 1990-2005); Shisana O et al (2005), p.43, Fig: 3.12: HIV prevalence among African females aged 15-49 years surveyed in the 2005 household survey compared to females surveyed in the 2004 antenatal clinic survey by province shows a range from Limpopo (14.0) to the Free State (30.9). But there is variation in prevalence rates within provinces, for instance in the Western Cape the antenatal data in the vast informal settlement area of Khayelitsha is twice as high as the provincial rate (Western Cape Department of Health, *HIV Prevalence in the Western Cape, Results of the HIV Antenatal Provincial and Area Surveys 2005*,); NSP (2007), pp.26-28.
[43] NSP (2007), pp.31-33.
[44] Barnett T, Whiteside A (2002), p.38 (Table 2.1) where the infections per 1,000 exposures for female to male transmission is 0.33 – 1, but male to female transmission is 1 – 2 infections. The transmission rates are considerably higher with male to male unprotected anal sex, needle stick injury, mother to child transmission and exposure to contaminated blood products. See also WHO (2003), pp. 68-69, for discussion on factors affecting the likelihood of acquiring HIV as a result of sexual assault.

as well as evidence presented in this report, suggests that women are also put a greater risk of transmission due to the discriminatory impact of gender roles and stereotypes. They are frequently unable to insist on condom use to protect themselves against the risk of HIV transmission by a male partner where they are economically, socially or culturally dependent on that partner or his family, or risk being subjected to violence as a result of suggesting condom use.[45] Their exposure to sexual violence and intimate partner violence increases their risk of HIV infection over time.[46] Women are less likely to have independent access to economic resources and recent research in South Africa has shown the direct positive correlation between women's access to economic resources and their ability to protect themselves from HIV infection and against violence.[47] In many countries, women also carry a disproportionate burden as carers once members of a household fall sick - a particular concern in a country like South Africa where AIDS affects a large part of the population.

Concerns of the UN Secretary-General's Task Force on Women and HIV in Southern Africa, 2004 [48]

Preventing HIV in girls and young women – stopping new infections in women and girls through interventions aimed at intergenerational sex and the cultural and socio-economic empowerment of women and girls

Getting girls in school and keeping them there – ensuring continued enrolment and retention of girls in school

Ending violence against women – protection of girls and women from exposure to HIV through sexual violence and intimidation

Securing property and inheritance rights – protecting women's and girls' right to own and inherit property

Supporting improved community-based care – protection against exploitation and provision of support in bearing the burden of care for people affected by HIV

Equitable access to care and treatment – ensuring equal access to care and treatment and protection from stigma, discrimination and violence related to women's HIV status.

As examined in the following chapters of this report, the scale of incidents of sexual and other forms of violence against women has remained persistently high in South Africa, continuing to place women at risk of HIV in the immediate or longer term. Considerable effort has been put into reforming the legal framework, medico-legal, police and criminal

[45] Jewkes R et al (1999), p.20; Mathews S, Abrahams N (2001) p.7.
[46] Dunkle K et al (2003); UN Secretary-General (2006), paras 157–165.
[47] Pronyk PM et al (2005); Barnett T, Whiteside A (2002), p.80. Ninety-five per cent of people living with the virus are living in developing countries. At the time of the UNGASS (2001), the proportion was estimated at 90%. See: http://www.ohchr.org/english/law/hiv.htm. More recently the WHO has cited the figure 95%. See http://www.who.int/immunization/topics/hiv/en/index1.html .
[48] UN Secretary General (2004). South Africa was one of the nine countries reviewed in the report. See: http://womenandaids.unaids.org/regional/docs/Report_of_SG's_Task_Force.pdf. Summarised in UNAIDS (2007). Review of Progress. *Secretary-General's Task Force on Women, Girls and HIV/AIDS in Southern Africa*, 2003-2007, Working Draft Summary Report, June 2007, UNAIDS/PCB(20)/CRP2, 19 June 2007. All the concerns listed apply to South Africa.

justice responses to gender-based violence. Nevertheless, women's lives continue to be scarred by violence or the threat of violence in under-policed, unsafe communities and in their homes. Nearly ten years after the Domestic Violence Act came into force and after the provision of training on their obligations by official and civil society organizations, there is still evidence that some members of the South African Police Service (SAPS) do not understand their legal responsibilities or do not feel under sufficient pressure to fulfil them. For women in abusive relationships, their access to places of safety also remains very difficult.

Violence against women is a persistent and devastating manifestation of gender-based discrimination. Other forms of discrimination in the social and cultural spheres can also act as barriers to women's access to prevention, treatment and care for HIV. There has been extensive transformation since 1994 of the legal framework to entrench gender equality, protect women's sexual and reproductive rights and their right not to be subjected to violence. However, the rural women whom AI interviewed were continuing to experience oppression in their relationships with male partners, within families and the wider community as a result of their low social status, economic marginalisation, and also in some cases because of their HIV status. These manifestations of their inequality as women were associated with a range of consequences, including abandonment, loss of their homes, failure to complete their education, inability to secure maintenance for their children, violations of their sexual and reproductive rights with an associated increased risk of HIV infection, and barriers to access to HIV-related health services and treatment adherence.

While there are many good reasons to test, and sound medical grounds for scaling up testing for HIV as recommended in the NSP, it is more complex in a context of gender inequality, poverty and violence. Where women are tested in greater numbers than men and with limited support, it can leave them vulnerable to stigma, discrimination, abandonment and violence.[49] The women AI interviewed spoke of their own experiences of powerlessness, verbal and physical abuse, threats of violence and abandonment in response to disclosing their HIV status.

Finally, poverty is a powerful factor acting as a barrier to access to health services, particularly for rural women who are disproportionately represented among the poor and unemployed. There has been a gradual improvement in the provision of HIV testing and counselling and preventative antiretroviral drugs to rape survivors, along with other initiatives to improve emergency medical and medico-legal services, but some survivors who lack economic resources and the support of NGOs still experience difficulties in adhering to treatment and remain at risk of HIV infection. While ART and other essential treatments for people living with HIV and AIDS are available free of charge, the circumstances of the women whom AI interviewed in KwaZulu Natal and Mpumalanga provinces indicate that women living in rural areas who do not have a secure income face serious challenges and in some cases complete inability to access treatment and ongoing care because they cannot afford the transport costs to get to the hospitals. Their ability to adhere to treatment is also

[49] By 2006 70 per cent of people receiving ART in South Africa were women (WHO, UNAIDS, UNICEF (2007), Figure 4, p.19). Women formed the majority in the 18 sub-Saharan countries listed, with South Africa having the most pronounced gender discrepancy. See http://www.who.int/hiv/mediacentre/universal_access_progress_report_en.pdf.

jeopardised because they cannot afford adequate food with which to take ART twice daily. Although some of the women did receive temporary disability grants, food supplements or other social assistance for their children's welfare, their economic circumstances remained precarious and affected their ability to access or continue their treatment. In addition their access to health services is further compromised by systemic challenges within the health system, in particular shortages of staffing and delays in government implementation of aspects of the HIV and AIDS treatment programme, such as providing sufficient accessible health care facilities to provide ART.

2. Violence against women and HIV

"He threatened to kill me and burn down the house if I did not take him back…So I returned back to stay with him." [Testimony of SS who had been raped and repeatedly beaten by her husband and was fearing receiving the results of her HIV test.][50]

"In spite of ample empirical evidence to this effect, states have yet to fully acknowledge and act upon the interconnection between the mutually reinforcing pandemics of VAW and HIV-AIDS". (UN Special Rapporteur on Violence against Women, July 2007)[51]

South Africa is continuing to experience a major HIV epidemic within a context of persistent and high levels of violence against women (VAW). As noted in the UN Secretary-General's Study in 2006 on patterns and consequences of VAW, this is a global phenomenon which is both a violation of women's human rights and prevents women from enjoying other human rights and fundamental freedoms. These include the rights to life and security of the person, and the rights to the highest attainable standard of physical and mental health, to education, work and housing and to participation in public life. VAW also perpetuates the subordination of women.[52] The co-existence of an epidemic of HIV infection has raised the costs of such violence for women in South Africa, both physically and psychologically. The UN Secretary General's Study observed that:

"For many women worldwide, the threat of violence exacerbates their risk of contracting HIV. …Studies show the increasing links between violence against women and HIV and demonstrate that HIV-infected women are more likely to have experienced violence, and … women who have experienced violence are at higher risk for HIV." [53]

The South African Constitution of 1996 guarantees that everyone has the right to freedom and security of the person, which includes *"the right…to be free from all forms of violence from either public or private sources"*.[54] Despite this constitutional guarantee thousands of women and girls experience sexual and other forms of violence every year in South Africa. In July 2007 the national Minister of Safety and Security, Mr Charles Nqakula, observed from analysis of the past six years of crime statistics that "the fact that instances of serious and violent crime are very high is disconcerting and unacceptable." They included rape, "indecent assault"[55] and attempts to commit these crimes. The Minister also observed that "poorer

[50] Interviewed on 6 May 2007 with the assistance of an interpreter.
[51] Special Rapporteur on Violence against Women (2007).
[52] UN Secretary-General (2006), paragraph 156; Marmot M (2007).
[53] UN Secretary-General (2006), paragraph 160.
[54] Section 12 (1) (c). The developments in the legal framework since 1994 are discussed in Chapter 3 below.
[55] Before the Criminal Law (Sexual Offences and Related Matters) Amendment Act came into force in December 2007 the crime of "indecent assault" included non-consensual anal penetration of either a female or male person. However the Constitutional Court on 10 May 2007 ruled that the common law definition of rape should be extended to include "non-consensual anal penetration of females", in a case involving an appeal against a conviction for rape in the lower courts by a man accused of sexually assaulting a young child (CCT 54/06, Masiya v the Director of Public Prosecutions & Another, para. 45); AI interview with TLAC (an Amicus Curiae in this case), Johannesburg, 14 May 2007. The offence is now included within the definition of rape under the new law.

communities" were experiencing "more violent crime than wealthier ones," and "at least two thirds of all serious and violent crimes happen between people who know one another and who will be found mostly within the confines of the same social environment.[56]

As is evident from the Minister's comments, violence or the threat of violence is a pervasive problem for many people in South Africa. Women and girls can experience gender-based violence or witness it from a very early age. Indicative of the scale of the problem were the results of a national survey conducted in the early 2000s, in which a third of the 1,000 women interviewed had experienced physical, sexual, emotional and economic abuse, most typically in their home environment, and two-thirds had experienced at least one form of abuse. The South African Human Rights Commission (SAHRC) concluded after hearings on school-based violence in 2006 that schools were the "most likely place where children would become victims of crime including crimes of sexual violence". A national cross-sectional study of nearly 270,000 high school students in 2002 identified an "expectation of sexual coercion among the youth".[57] A majority of the women whom AI interviewed in May 2007 had experienced, witnessed or were aware of incidents of violence in the home or rapes occurring in the wider community, including in schools or while en route to school, or on farms where some of the women had worked as seasonal contract workers.

The consequences for the health and psychological well-being of the women and girls subjected to these forms of violence can be devastating. At the same time violence against women and girls can have damaging psychological effects on boys who witness their mothers being beaten or their sisters' abuse at the hands of fathers and partners. Research evidence indicates that men who had witnessed domestic violence during their childhood were responsible for significantly higher levels of abuse against women in their adult lives, as opposed to men who had not witnessed violence against women in their childhood.[58] For women and girls experiencing violence and abuse, the consequences are immediate, but can also be longer-term, including through provoking a change of behaviour in the victim. As shown in the results of a large scale 2003 study, "child sexual assault and forced first intercourse" are associated in later adult life with an increased vulnerability to "intimate partner violence and…sexual assault by non-partners." These events in turn are "generally associated with increased HIV risk behaviours."[59] In addition, women who are living in such circumstances are at increased risk of HIV infection from their violent partners, as men who are perpetrators of violence are more likely to engage in risk taking behaviour themselves.[60]

[56] Justice, Crime Prevention & Security Cluster media briefing on release of crime statistics, Charles Nqakula, MP, Minister for Safety and Security, Issued by Secretariat for Safety and Security, 3 July 2007.
[57] Rasool, S et al (2002); SAHRC (2006b); Andersson N et al (2004). Regarding levels of violence against girls, including at school, see also Bower C (2006); REACH (2006); CASE (2005a); Jewkes R et al (2002); Human Rights Watch (2001). Andersson, N et al (2004) found from the results of their national cross-sectional study that nearly three-fifths of the respondents believed that "sexual violence does not include forcing sex with someone you know". The researchers concluded that "the apparent expectation of sexual coercion among the youth and the associated adaptive attitudes contribute to a culture of sexual violence. Males and females were affected similarly and showed a reaction to and a reinforcement of their everyday risk of sexual violence" (Table 1 and pp. 2-4). AI interview with CIETAfrica, Johannesburg, 31 October 2006.
[58] Abrahams N et al (1999), p.12 (Table 5). See also Sikweyiya et al (2007), Mathe S (2007), CADRE (2004), Sideris (2005) and Sideris T (2002).
[59] Dunkle KL et al (2003). See also Shisana et al (2005).
[60] Jewkes R et al (2006). See also Sikweyiya et al (2007); Niehaus, I (2005).

South Africa has obligations under both national law and international human rights law to reduce, through violence prevention programmes and the health sector response, the risks of HIV transmission after rape or over the longterm for women living in abusive relationships. They also have an obligation to provide redress for survivors of violence against women through an effective criminal justice and social support system. Although the scale of incidents of sexual and other forms of violence against women remains persistently high, as indicated below, the state has taken some measures to improve the response of the criminal justice system to these crimes and access to civil remedies in cases of domestic violence. The quality of the policing and justice response may decline though if key reforms are not sustained. After some national government resistance there has been a gradual improvement in the provision of HIV testing and counselling and preventative antiretroviral drugs to rape survivors, along with other initiatives to improve emergency medical and medico-legal services. Some survivors who lack economic resources and the support of NGOs do experience difficulties in adhering to treatment and remain at risk of HIV infection. For the women whom AI interviewed, their lives were still scarred by violence or the threat of violence in unsafe communities and within their homes. The police and municipal authorities, with the support of local communities, must act urgently to improve the safety of the environments in which rural women are living.

Sexual violence and its consequences

> *"We live in fear. There is nothing we can do to protect ourselves."* (Testimony of LE, a rape survivor living with HIV in rural KwaZulu Natal)[61]

> *"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…"* (South African Supreme Court of Appeal, S v Chapman)[62]

The World Health Organization has commented on the "profound impact" of sexual violence on the physical and mental health of survivors. Its impact can include physical injury and is associated with "an increased risk of a range of sexual and reproductive health problems, with both immediate and long-term consequences." There is also a serious and possibly long-term impact on the victim's mental health.[63] The link between gender-based violence and HIV is most apparent in respect to the crime of rape, which can lead to direct HIV transmission. Due to the high HIV prevalence and high levels of sexual violence in South Africa, women are at risk of contracting HIV as a consequence of rape.[64] The likelihood of transmission during an incident of rape can be exacerbated by a number of factors. These include that perpetrators

[61] Interviewed on 7 May 2007 with the assistance of an interpreter.
[62] 1997 (3) SA 341 (A) at 344J-45B.
[63] WHO (2002b), p.149. (Internal references deleted.)
[64] Shisana O et al (2005), p.1, noting that "[Women and girls] are more vulnerable to HIV and it has been established that the lower status and disempowerment of women contribute to their higher infection rates. Younger women, especially teenage girls, are especially vulnerable to HIV infection, due to the immaturity of their reproductive systems as well as likelier exposure to sexual coercion…and the relationship between sex and violence, which includes vulnerability to rape".

rarely use a condom, the "high rate of multiple perpetrator" rapes,[65] the frequency of sexual assaults and the presence of sexually transmitted infections (STIs). In a violent sexual assault a victim may also receive wounds in the genital area and associated bleeding which can further increase chances of transmission of the virus.[66] The risk of traumatic injury is higher in the case of young children.[67] Police statistics for reported cases of rape and indecent assault year on year have shown that as much as 40 per cent of these crimes have been committed against children under18 years of age.[68]

Reported cases of rape amounted nationally to 117 per 100,000 of the population in the financial year April 2006 to March 2007, with a range from 80.6 (Limpopo) to 142.8 (Northern Cape) in the nine provinces.[69] Research and support organizations believe, however, that the actual figures annually are much higher than those cases reported to the police, because of the social and economic pressures which discourage women from reporting rape.[70] Although the number of reported rapes over six years, beginning in 2001/2002 and ending in the year 2006/2007, had decreased by 4.2 per cent overall according to police statistics, the total for the most recent reported year was still high, at 52,617. In addition to this figure should be added the 9,327 reported cases of "indecent assault", which include incidents of anal rape or other types of sexual assault which did not fall within the then legal definition of rape.[71] In December the Minister of Safety and Security released new crime statistics for the period April to September 2007 including 22,887 reported rapes and 4,249 indecent assault cases.

Police analysis in 2007 of reported cases indicated that "76 per cent of rapes covered by the sample studied involved people known to one another." In just under a fifth of the total

[65] Christofides N et al (2006). p.37; Albertyn C et al (2007) referring to the observation of Rape Crisis in Cape Town that 55% of the women they counselled for rape had been victims of multiple perpetrator rapes; Artz L (2002).

[66] WHO (2003), pp.68-69. According to the WHO *Guidelines*, there is no accurate data on the number of victims of sexual violence who become infected with HIV as a result of assault, but the risk level can be increased by factors such as indicated in the text above and others including the type of assault (whether involving anal, vaginal, or oral assault or the insertion of objects), whether and where on/in the body ejaculation occurred and the viral load of the perpetrator. The DoH Western Cape Treatment Guidelines for the Use of Post-Exposure Prophylaxis (PEP) (discussed further below) require a different antiretroviral drug regime in cases where the "risk of exposure is assessed as high under any one of the following conditions: multiple perpetrators/anal penetration/obvious trauma to the genital area/known HIV positivity of one of the perpetrators". See also Denny L (2002) and Kalichman C et al (2007).

[67] WHO (2003), chapter 7 (especially sub-section 7.3.2 on genito-anal findings).

[68] The Annual Report of the SAPS for 2005/2006, for instance, states that 42.7 % (23, 453) of reported rapes were against children (under 18 years) (www.saps.gov.za/saps_profile/strategic_framework/annual_report/20052006/prog_performance) , (Table 12: Crimes against women and children). See also Kistner U et al (2004), pp. 15-16, who cite police, NGO service–providing organizations and academic research sources on the high proportion of sexual abuse and rape cases involving children under 18 years. See also Bower C (2006) and CASE (2005a). Information provided to AI in meetings with Children's Rights Alliance, Durban, 26 October 2006; Childline, Johannesburg, 30 October 2006; GRIP, Nelspruit, 28 March and 2 May 2007; RAPCAN, Cape Town, 11 May 2007.

[69] Annual Report of the SAPS for 2006/2007, Appendix A: National Crime Situation, Table 14: Fluctuations in serious crime trends between the 2005/2006 and 2006/2007 financial years per province.

[70] Jewkes R and Abrahams N (2002) who cite figures of more than 2000 acts of rape or attempted rape per 100,000 women each year, based on gap between reported figures and the numbers of rape survivors who are known by support organizations not to have reported to the police." See also Dosekun S (2007); Vetten L (2007); Albertyn C et al (2007).

[71] SAPS crime analysis report 3 July 2007, p. 7 (Table 1). available on www.saps.gov.za. The Criminal Law (Sexual and Related Matters) Amendment Act, which was signed into law by President Mbeki in December 2007, widens the definition of the crime of rape to include unlawful and intentional acts of "sexual penetration" of a person without that person's consent, with sexual penetration defined to include the penetration of genital organs, anus or mouth by any body part or object.

cases the perpetrators were relatives.[72] Women in certain areas also seem to be at greater risk of violence. From an analysis of crime patterns at the police station area-level, it appears that 40 per cent of the cases of rape and other "socially motivated contact crimes" such as murder and assault with intent to cause grievous bodily harm (assault GBH), which were reported in 2006/2007, had occurred in only ten per cent of the 1,105 police station jurisdictions.[73] Of the areas where AI conducted its interviews in May 2007, all but one fell within the areas of the police stations with the highest reporting rates.

These official statistics and accompanying analysis indicate that many South African women live in a general environment of high levels of violent crime, including rape, which affects their lives at home, in the community and wider society, placing them at risk of HIV infection in an accompanying context of high HIV prevalence levels.

Among the women whom AI interviewed, a number of them reported being raped and living in a generally threatening environment.

SS's story [74]

Thirty-two-year-old SS was raped by her husband in 2006. He had been physically abusing her for more than seven of their 11 year marriage. Past abuses included beatings and attacks with broken bottles. *"The abuse started when he got work and he started buying alcohol,"* SS told AI. She had been to the police station several times and had lodged a criminal charge at least once, which led to his conviction on an assault charge and six months imprisonment. When her husband was released from jail he found her living in the home of his parents and he smashed up the door and windows to gain access to her. *"He threatened to kill me and burn down the house if I did not take him back…So I returned back to stay with him."* Her only income came from two child social grants. He did not support the children. *"If I asked for clothes or food, he beat me,"* she said.

Sometimes SS's injuries were so severe she had to go to the clinic. While the nurses knew that she was being abused and encouraged her to go to the police for help, there were no shelters for victims of abuse in the area. Once when she tried to escape, her husband followed and found her. She returned home with him out of fear of violence against the relative who was sheltering her. When she finally refused intercourse with him, in October 2006, he beat her and then raped her in front of their children. With the assistance of an NGO support organization, she laid a criminal charge at the police station and he was arrested. He was released on bail a month later, but was himself murdered by unknown gunmen. SS, who had undergone a medical examination and tests at a hospital following her rape, told AI in May 2007 that she been too unwell and too short of money to return to the hospital to learn the results of her HIV test.

The pervasive and longstanding nature of violence and insecurity in women's lives was exemplified in the story of 45-year-old RE. A mother of three children and a widow for five years following the death of her husband from AIDS-related illness, RE had had her own

[72] Media Statement from the Office of The National Commissioner of the South African Police**,** Pretoria, 3 July 2007, which summarised the results of the analysis. In 89% of cases of assault causing grievous bodily harm (assault-GBH) and common assault, and 82% of murders, the perpetrators and victims were known to each other. SAPS Crime Analysis Report, p.28 (Table 6). Available on: www.saps.org.za.
[73] SAPS Crime Analysis Report, p. 33 (Table 9).
[74] Interviewed on 6 May 2007 with the assistance of an interpreter.

HIV-infected status confirmed in 1997. She told AI that she had been raped when she was about 12 years old by an "old man" who lived in her community in KwaZulu Natal.[75]

> *"He was just like that; he was raping people, and if we could find out we took him to the police, but he was always getting away with that. I can't remember all the story, but I still remember that* [incident] *because he beat me, nearly killed me. …[H]e came to my home – my mother and I were there…He nearly also killed my mother. He beat her, but he did not rape her. He raped me, and then when I ran home – because I was* [on the way back] *from school – he came after me again and that's where he beat my mother."*

Now she was currently living in an area in which a young woman had recently been raped. People in the local community were afraid of the suspected perpetrator, as he had a reputation for raping young women at knife point. They told RE that she *"must not report him to the police because it is too dangerous"*. She did however report the incident to a woman whom she referred to as the "mother" who looks after the community. RE fervently hoped that she could find some additional income which would enable her to move from this place she described as *"too dangerous for us"* to live in.

The sense of vulnerability experienced by women living in unsafe, poorly policed areas is also evident in the comments of 39-year-old EZ, who was living with her three children and two grandchildren in Mpumalanga. She told AI that she was worried about the safety of her girls and tried to prevent them from taking risks, such as going out at night or going to shebeens.[76] In addition she worried about their vulnerability as a female-only household. *"I am trying to keep it quiet that I am staying alone without a man in the home,"* she told AI.[77]

Twenty-four-year-old LE, who supported herself selling fish in the local area and lived with her older "adoptive" sister in a rural area in KwaZulu Natal, was raped one night in February 2007. She was sleeping at the home of a woman relative, who was also raped. The men had broken into the home and covered the women's faces with pillows so they could not identify the perpetrators. LE told AI that what she most wished for was "a home and to feel at peace". She was not getting on with her sister and *"we live in fear. There is nothing we can do to protect ourselves"*. She found her situation so troubling that sometimes she felt like taking her own life.[78]

The effects of insecurity compounded by social stigma increased the difficulties for another young woman, 23-year-old SW who was trying to re-establish her life after being raped in 2006. She had moved to her grandmothers' home after her mother's death from AIDS-related illness in 2006. However she feared she would be chased out of this house because of their hostility towards people they believe have AIDS. SW had learnt that she was HIV-positive at the time of her mother's illness. She told AI that while she could leave her grandmothers and stay with her auntie, who accepted her status, she feared to stay there. It was from that house she had been abducted at night and then raped in a football field by a

[75] Interviewed on 7 May 2007.
[76] an unlicensed drinking tavern in predominantly black residential areas.
[77] Interviewed on 5 May 2007 with the assistance of an interpreter.
[78] Interviewed on 7 May with the assistance of an interpreter.

man wearing a balaclava. The perpetrator had so far as she knew not been arrested. She had lost her job due to the impact of the rape on her health and had no resources to find her own place to live.[79]

South Africa has obligations under international human rights law, as well as under national law, to prevent violence against women and provide access to effective remedies and redress for women subjected to violence. Under the Protocol to the African Charter on the Rights of Women in Africa, for instance, *"States Parties shall…adopt such …legislative, administrative, social and economic measures as may be necessary to ensure the prevention, punishment and eradication of all forms of violence against women"*.[80] Some initiatives have been taken by the state to improve the criminal justice response to crimes of rape and to a lesser extent to address the lack of safety in local communities. The former initiatives include:

- strengthening the coordination of the work of police investigating officers and medical practitioners involved in examining rape survivors and gathering forensic evidence and, in some cases, the development of 'one-stop' centres for the provision of medical, investigative, prosecutorial and psychological services for rape survivors;
- the development of national policy guidelines for the handling of victims of sexual offences and national management guidelines for care of victims of sexual assault;
- the development of specialised sexual offences courts which have achieved a higher conviction rate in the prosecution of rape and other sexual offences;
- the training of criminal justice personnel including police in the principles of "victim empowerment" and the establishment in some police stations of "victim friendly" facilities, often in collaboration with NGO support organizations;
- the reform of the legal framework for prosecuting sexual offences, in particular by widening the definition of what constitutes rape to include oral and anal, as well as vaginal, penetration by a body part or object without the consent of the victim, which may be confirmed by the presence of 'coercive circumstances'; and, more controversially,
- minimum sentencing legislation in cases of rape.[81]

[79] Interviewed on 6 May 2007 with the assistance of an interpreter.
[80] Article 4(2) (b).
[81] Vetten L and Jaarsveld FV (2008); Albertyn C et al (2007); Vetten L (2007); Artz L and Smythe D (2007; Frank C (2007); Combrinck H and Skepu Z (2003); Amnesty International (2002). On government sector instructions and training for officials working within the criminal justice system under the framework of "victim empowerment", see for instance Department of Justice and Constitutional Development (DOJ&CD), Workshop Report: Inter-Sectoral Training on the Victims Charter, June 2007. DOJ&CD, Service Charter for Victims of Crime in South Africa, Consolidation of the present legal framework relating to the rights of and services provided to victims of crime; DOJ&CD, Minimum Standards on Services for Victims of Crime (Available at: http://www.doj.gov.za/VC/VCmain.htm). "SAPS National Instruction 7/1999 Version 02.00 in terms of section 18(3) of the DV Act 116 of 1998" (Available at: www.info.gov.za/gazette/notices/2006/28581.pdf)

Part of the SAPS Sexual Assault Evidence Collection Kit introduced to improve the gathering of medical evidence by doctors and the management of the chain of custody of this evidence before and after it is handed over to the police. ©AI 2002

However a number of concerns remain. The Department of Justice and Constitutional Development appears to have decided not to expand the development of the specialised sexual offences courts. Rape remains a difficult crime to prosecute and requires a high level of training for prosecutors and presiding officers. In the ordinary courts the conviction rates are low. In a recent study of the outcomes of over 2,000 police investigation cases in Gauteng province, 359 of the cases went to trial resulting in convictions for rape in about 87 cases, equivalent to less than five per cent of the original group.[82] Advocacy organizations who were involved in the decade-long process of reforming the sexual offences legislation have expressed concern that the final version of the reformed law has eroded the protections afforded to rape complainants and other vulnerable witnesses contained in the initial draft law.[83] The controversial trial on a rape charge of the former Deputy President, Jacob Zuma, in 2006 vividly illustrated the risks for complainants in seeking justice through the courts. The presiding judge allowed defence counsel to extensively question the complainant about her past sexual history, took into account the complainant's clothing and conduct, measured her behaviour against his assumptions of how a 'real' rape survivor may act and made no comment on the intimidating effect on the complainant of the conduct of the defendant's supporters outside the court room.[84]

The professionalism of the police response to reports of sexual violence may have been weakened by the decision taken in 2006 by police management to decentralise specialist police units, including the Family Violence, Child Protection and Sexual Offences Unit (FCS). Members of the Unit have been redistributed to local police stations, but in a manner which appears to have left them without adequate support and at risk of being de-skilled.[85] Some police stations still do not have separate victim-friendly facilities to enable complainants to be interviewed away from the charge office.

[82] Vetten L and Jaarsveld FV (2007); AI interviews with CSVR and TLAC, Johannesburg, 27 October 2006 and 14 May 2007 regarding this case "attrition" study undertaken with the Medical Research Council.
[83] Consortium on Violence Against Women, Submission to the National Council of Provinces, 12 September 2007 (Available at: http://www.tlac.org.za/content/view/24/40/); National Working Group on Sexual Offences, Press Release: Mixed Review for the New Sexual Offences Act, 14 December 2007; Artz L, Smythe D (2007).
[84] Ruling of the High Court (Witwatersrand Local Division) In the matter between the State v J G Zuma, 4 May 2006; Vetten L (2007). The defendant's supporters, who gathered outside the court building during the course of the trial, vocally condemned the complainant, and hectored and threatened anti-violence campaigners and her supporters, who felt police deployed near the court failed to act impartially (AI interviews with representatives of POWA, FEW, TLAC and PWN, Johannesburg, October 2006). See the comments of Delphine Serumaga and other gender rights activists on the negative impact of the trial for the protection of women's rights, in Pambazuka Newsletter, 11 May 2006.) See also Vetten L and Jaarsveld FV (2008) for an analysis of the attitudes displayed by presiding officers in rape trials heard in the regional magistrate and High Courts.
[85] Omar B (2007), p.25; interview with Childline South Africa, Johannesburg, 30 October 2006; interview with GRIP, Nelspruit, 28 March 2007; interview with RAPCAN, by phone, 19 December 2007.

Finally, in regard to prevention, much more needs to be done by municipal authorities in cooperation with the police, businesses and local rural communities to improve women's physical security by identifying and addressing threats to their safety in the physical environment. AI visited a number of areas where poor or no lighting, high bushes along pathways and inadequate transport links increased the risks of violence for women and girls on a daily basis. Police management could also give greater priority to increasing the level of personnel, vehicles and equipment for rural-based police stations.[86]

Campaigners, at the time of the trial of Jacob Zuma, highlighting the under-reporting of rape and the pressures on rape complainants.
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Domestic Violence as a long-term threat to women's health

"To the extent that [domestic violence] is systemic, pervasive and overwhelmingly gender-specific, domestic violence both reflects and reinforces patriarchal domination and does so in a particularly brutal form.…The non-sexist society promised in the foundational clause of the Constitution [section 1], and the right to equality and non-discrimination

[86] The KwaZulu Natal Network Against Violence Against Women initiated a "Women's Safety Audit" in KwaMakhutha, Durban, in partnership with Safer Cities and eThekwini Municipality's Department of Community and Liaison and subsequently widened its geographical scope through the KZN Victim Empowerment Forum and the assistance of the Department of Social Welfare (information provided to AI by the Network Coordinator in 2006 and 2007).

guaranteed by section 9, are undermined when spouse-batterers enjoy impunity."[87] *(South African Constitutional Court in S v Baloyi)*

Domestic violence, particularly intimate partner violence, may involve physical and sexual violence, as well as threats of violence and psychological and emotional abuse, and has been identified by the WHO as a serious health problem internationally affecting up to 60 per cent of women across different countries.[88] The phenomenon is defined by unequal gender relations and has an impact on women's ability to protect themselves from HIV infection. The UN Committee on the Elimination of Discrimination against Women (CEDAW), in General Recommendation 19,[89] described "family violence as one of the most insidious forms of violence against women" which is evident in "violence of all kinds" and underpinned by "traditional attitudes" and a lack of economic independence which forces many women to stay in violent relationships. CEDAW concluded that "[t]hese forms of violence put women's health at risk and impair their ability to participate in family life and public life on a basis of equality."

In the Southern African region the results of a large scale household survey conducted in eight countries showed that nearly a fifth of the women interviewed reported being a victim of partner physical violence in the preceding year. The study found that men having multiple concurrent partners was significantly associated with the occurrence of partner physical violence. Another significant factor associated with violence was the holding by men of certain attitudes about sexuality and sexual violence. These beliefs included that women do not have the right to refuse sex to husbands and boyfriends; that forcing one's partner to have sex is not rape; and women sometimes deserve to be beaten. The women who reported experiencing partner physical violence were significantly more likely to believe that they were at risk of getting HIV.[90] South African based-studies have found that women who experience intimate partner violence are at long-term increased risk of HIV infection, particularly where their partners were involved in multiple concurrent, unprotected sexual relationships.[91]

The scale of the problem in South Africa has been difficult to assess accurately as the police do not appear to keep separate figures for "domestic violence" or at least include them in their public crime statistics. However, in late 2007 the SAPS submitted reports to the Parliamentary Portfolio Committee on Safety and Security in which they noted a total of 88,784 "domestic violence incidents" had been recorded between 1 July 2006 and June 2007.[92] These cases would have included a range of forms of abuse as, under the 1998 DVA, "domestic violence" is defined to include physical, sexual, emotional, verbal, psychological and economic abuse; intimidation, harassment, stalking, damage to property; entry into

[87] Constitutional Court ruling in The State v Godfrey Baloyi Appellant, the Minister of Justice First Intervening Party, The Commission on Gender Equality, Second Intervening Party, 3 December 1999 (Case CCT 29/99), para.12.
[88] World Health Organization (2002b); Garcia-Moreno C et al (2006); Amnesty International (2004).
[89] CEDAW. UN Document A/47/38 at para. 23. Available at: http://www.un.org/womenwatch/daw/cedaw/recommendations/recomm.htm
[90] Andersson N et al (2007), pp.6-9. The survey was conducted in Botswana, Lesotho, Swaziland, Malawi, Mozambique, Namibia, Zambia and Zimbabwe in 2002.
[91] Dunkle K et al (2003); Jewkes R et al (2006); Fox AM et al (2007).
[92] SAPS Domestic Violence Report 1 July – 31 December 2006, available at http://www.pmg.org.za/docs/2007/070912saps.htm .

complainant's residence without consent where the parties do not share the same residence; or any other controlling or abusive behaviour towards a complainant, where such conduct harms, or may cause imminent harm to the safety, health or well-being of the complainant.[93] Between April 2006 and March 2007, 63,000 applications for protection orders, under the terms of the DVA, were confirmed by the courts.[94]

Further insight into the levels of violence which may be affecting women in their homes can be gleaned from the SAPS crime statistics for incidents of assault GBH. The SAPS noted that a quarter of the perpetrators were relatives and in nearly 90 per cent of the cases the victim knew the perpetrator.[95] The actual number of reported incidents of assault GBH for the year 2006/2007 – 218,030 – is indicative of serious levels of interpersonal violence, with one quarter or some 55,000 incidents involving family members.[96] To these figures could also be added the number of cases of murder or attempted murder, both of which could be relevant for an analysis of domestic violence trends. South African legal researchers reviewing the results of community-based, local and regional studies noted that the estimates range from one in two to one in six women experiencing domestic violence.[97] A hospital-based survey reported that more than one third of women from a low-income community had experienced domestic violence at some stage.[98] Half of all South African women killed in 1999 were "killed by their intimate partners, with violence a factor in many of these relationships."[99]

Among the women whom AI interviewed who had experienced domestic violence, there were a variety of social, economic, cultural and institutional factors which obstructed their access to effective remedies and safety.

EZ's story[100]

Thirty-nine-year-old EZ was living with her three children and two grandchildren in Mpumalanga when she told AI about her efforts to obtain protection when she was being abused by her husband. In addition he had admitted to having extramarital relationships, but refused to use a condom during sex with her. Eventually she sought police assistance, travelling to a police station several hours away from her home intending to lay a charge against him for beating her. While *"I was busy talking to the charge office"*, she told AI, *"I was overheard by this relative who said stop, don't take this case. And the charge office did stop taking my case"*. The intervener was a relative of her husband and also, she said, a SAPS member. He told her that he would talk to her husband about his conduct. Whether or not he did do so, her husband continued beating her and eventually she took steps to separate from him

[93] Act 116 of 1998, section 1 (viii) (a – j). The Preamble to the DVA acknowledged that "there is a high incidence of domestic violence within South African society". The Act was passed by parliament at the end of a lengthy review of existing ineffective legislation. The review was conducted by the South African Law Commission which received a wide range of expert and civil society submissions relating to the weaknesses in the 1993 Prevention of Family Violence Act, the nature of the phenomenon and the mechanisms for prevention and redress (Parenzee P et al (2001), pp.2-3; Albertyn C et al (2007), pp. 323-324.
[94] Department of Justice and Constitutional Development, Annual Report 2006/2007, p.58. http://www.doj.gov.za/reports/anr200607/200607%20content.htm
[95] SAPS Crime Analysis Report, p.28 (Table 6).
[96] SAPS Crime Analysis Report, p7 (Table 1), with "relatives/friends/acquaintances" collectively responsible for 71.5 per cent of incidents of assault GBH, or 155,892 cases.
[97] Albertyn C et al (2007), p.321; Rasool S et al, (2002). pp. xv, 27-44.
[98] Mbokota M, Moodley J (2003).
[99] Mathews S et al (2004); Albertyn C et al (2007), pp.295, 399.
[100] Interviewed on 5 May 2007 with the assistance of an interpreter.

because of his violent behaviour. He was now living with his second wife. EZ, who had tested HIV positive in early 2007, had had to give up her piece work on farms due to ill-health.

In EZ's case the police had failed her by not upholding their legal duty to assist and inform a complainant of her rights and the available remedies.[101] Other women had felt unable to approach a police station or were unaware of their right to seek help or lay a charge. In the case of 47-year-old AS she had turned to her husband's family for support when he repeatedly physically assaulted her. Her own parents were not around to offer help as they had passed away, and she had no secure income of her own. Now living as a widow with her three daughters, she told AI that her husband had hit her when they had quarrels over family matters.[102] Although sometimes suffering serious injuries, she did not go to the clinic. *"I just cleaned my own wounds,"* she said. However when she told her husband's family what was happening, *"[t]hey used to talk to him to calm him down* [but] *there was no mention of going to the police."* Most of the time he was away working at a mine near Johannesburg and sent home money. He visited her for several days only every three months. They did not use condoms, but, she said, he did not force her to have sex. Seven years after her husband passed away *"from TB* [tuberculosis]*"*, she went to the clinic because she had become too ill to continue doing piece work on the local farms. She tested for HIV and found she was positive.

One of the women whom AI interviewed did manage to obtain a "protection order", a remedy available under the DVA through the courts. Forty-three-year-old TD obtained the order against her husband after a long period of abuse during which he hit her with sticks, threatened her with a home-made gun and beat their nine-year-old son. TD, a mother of seven children and living in KwaZulu Natal, told AI that she had finally taken the risk of giving evidence against her husband in court after he had threatened to rape their daughter.[103] Before she was driven to take this step she had tried at various times to seek help from her husband's family, but they did nothing. Eventually a member of her own family had approached the local *induna* (headman). Their intervention may have been what prompted her husband to make an apology, on the basis of which she decided to return to him. However his violent behaviour, which she said was triggered by his heavy drinking, did not change. Now the protection order was making her feel more secure, but she had a new worry. Not long before her interview with AI, TD had taken an HIV test because she wanted to know her status. The clinic advised her to return for a second test to confirm the result. She commented that she and her husband had never used condoms and she felt very vulnerable. *"The man might be having other partners…You'll think you are safe when you are not."*

These three women's stories, along with that of SS described earlier, illustrate some of the difficulties which rural women face when needing protection from a violent partner. These include a lack of independent economic resources and alternative housing or places of safety, the isolating effect of being dependent for support on their husband's family, the lack of family encouragement to seek help from the police or the courts, and at least in the case of EZ

[101] DVA Section 2 which imposes positive legal duties on the police when an incident of domestic violence is reported.
[102] Interviewed on 5 May 2007 with the assistance of an interpreter.
[103] Interviewed on 7 May 2007 with the assistance of an interpreter.

a failure of the police to provide an impartial service and fulfil their legal obligations. Where this kind of failure forms a persistent pattern, it can discourage other women from taking the risk and finding money for travel to a police station for assistance. In two cases, that of SS and TD, the police and the courts had responded appropriately with a protection order or criminal proceedings. However both of the women had endured years of abuse beforehand. All of the women had been placed at risk of HIV infection while living with their violent partners, at least one of whom admitted to other sexual relationships. As observed in one study from interviews with women survivors of domestic violence living in Gauteng province,

> *"[a]lthough the connections of physical and sexual assault posed the most direct risk for HIV, emotional and economic abuse also intertwined to inhibit HIV risk reduction efforts. [W]omen in theoretically monogamous, closed sexual relationships may be put at risk of HIV and other STIs by the high-risk behaviours of their partners over which they have little or no control."*[104]

During its visit in May 2007 AI was informed about but did not have the opportunity to seek interviews with other women whose cases were raised by support organizations or health workers. These cases were raised by individuals who had witnessed the police conduct in question. Several of the cases raised contained allegations that SAPS members from a particular Mpumalanga police station had failed to speak directly to complainants, although they showed visible injuries from being beaten on the head and elsewhere, including in one case with a knobkerrie,[105] and were threatened with firearms; the police had refused to co-operate with a request for a protection order unless the complainant lodged a criminal case, and failed to recognize the need to seize the weapons involved in the incidents.[106]

In a further disturbing case, AI was informed by health care workers at a hospital in KwaZulu Natal that they had intervened at a police station to urge them to take steps against the father of a 24-year-old woman who was pregnant for the fourth time as a result of repeated acts of rape he committed against her. The young woman was HIV-infected, ill with TB, had an epilepsy condition and had already given birth to three children by her father. The police response reportedly was to refuse to go to the house and instead to insist that she must travel to the police station to lodge a criminal complaint. In the view of one of the health care workers, the police do not really see it as their responsibility to deal with violence cases unless the family or victim report directly to the police station.

The Preamble to the DVA acknowledged the severity of the problem of violence against women and noted that the legislation had as its purpose providing victims the maximum protection under the law. The DVA imposed specific obligations on the National Commissioner of Police and the National Director of Public Prosecutions to issue instructions and develop policy for the effective implementation of the new law. Police members have specific legal obligations under the DVA in response to complaints of domestic violence. Failures in the execution of these duties constitute misconduct under the Act and SAPS

[104] Fox AM et al (2007), pp. 589, 598.
[105] A type of short wooden club with a heavy knob on one end which has been used as a "traditional" weapon in South Africa.
[106] Information brought to AI's attention by organizations in Nelspruit, 3 May 2007.

national instructions.[107] The National Commissioner of Police in his report to parliament at the end of 2007 acknowledged that the number of complaints against the SAPS for failing to undertake their duties under the DVA had been rising.[108] The cases referred to above indicate a number of breaches of police obligations, including failing to advise complainants of the availability of civil remedies and how to have access to them, such as obtaining a protection order or a court order for the seizure of a firearm or other defined 'dangerous weapons', and failing to act impartially and without gender bias on receipt of a complaint and in circumstances where the safety of the complainant was at stake.

Nearly ten years after the DVA came into force and after the provision of training on their obligations by official and civil society organizations, there is still evidence that some members of the SAPS do not understand their legal responsibilities or do not feel under sufficient pressure to fulfil them. A view that these are "family matters" still persists among some police officers, an attitude which may be reinforced by policing priorities which emphasise combating crimes which have an impact on the economy and more influential sectors of society. The professionalism of the police response to reports of domestic violence may also have been weakened by the decision taken in 2006 by police management to decentralise specialist police units, including the FCS. Members of the Unit have been redistributed to local police stations, but in a manner which appears to have left them without adequate support and at risk of being deskilled.[109]

As stated in the Preamble to the DVA, "victims of domestic violence are among the most vulnerable members of society". For rural women seeking assistance from the police and the courts, their efforts can be undermined by fear, family pressures, cultural expectations, the burden of child care responsibilities, lack of resources and, ultimately, by an indifferent and unprofessional response from the police. The policing authorities have a responsibility to ensure that all members of the police service, in particular those who have station level duties, are fully trained on their legal obligations under the DVA and in an understanding of the implications of women's right to equality and "to be free from all forms of violence from either public or private sources". Disciplinary proceedings should be instituted where these obligations are not observed.

Finally, urgent attention is needed to increase information about and the availability of places of safety. All of the women interviewed by AI, when asked if there were shelters for women experiencing violence in their homes, replied that they were not aware of any. Their only resort was to go back to their parents or other relatives' homes, but with the risk of being

[107] Parenzee P et al (2001), pp.11-13; DVA Sections 18 (3) and (4); SAPS National Instruction 7/1999 Version 02.00 in terms of section 18(3) of the DVA Act 116 of 1998 (Available at: www.info.gov.za/gazette/notices/2006/28581.pdf).

[108] Domestic Violence Act: Implementation Reports 2006 by ICD and SAPS 12 September 2007 and 31 October 2007 (available at: http://www.pmg.org.za/docs/2007/070912saps.htm; http://www.pmg.org.za/viewminute.php?id=9685). Section 18 (4) of the DVA provides that in the event of misconduct the police oversight body, the Independent Complaints Directorate (ICD), has the authority to investigate such misconduct. The National Commissioner's comments on the increase in complaints against the police referred to the ICD's reports to parliament documenting an increase in service complaints. See Parenzee P et al (2001) for a detailed analysis of police failings in the implementation of the DVA, based on case docket analysis, court observations and interviews with criminal justice officials.

[109] Omar B (2007), p.25; interview with Childline South Africa, Johannesburg, 30 October 2006; interview with GRIP, Nelspruit, 28 March 2007; interview with RAPCAN, by phone, 19 December 2007.

found. A support organization in Mpumalanga informed AI that they were aware of one shelter which allowed a woman to stay for three months, including with her children, but transport was difficult to arrange. According to the national Department of Social Development, which is responsible for approving provincial plans within agreed national policy guidelines, in addition to the Louieville Women's Support Centre in Mpumalanga which was opened in 2002, a further shelter was opened in 2006, in Badplaas, and planning for a third one was underway.[110] The Western Cape provincial government website lists six facilities for abused women.[111] KwaZulu Natal's provincial Department of Health website provides information on the nature of women abuse and services for victims including the Crisis Care Centres based at hospitals and clinics, and a help line linking the caller to a counsellor.[112] However there appeared to be no facilities available allowing women to stay for more than very brief periods, often no more than a night.[113] NGOs such as People Opposing Women Abuse (POWA) run several shelters in Gauteng Province which are financially supported by the Department of Social Development and international donors.[114] One NGO-run shelter in South Coast area of KwaZulu Natal, Sinethemba, which AI visited in May 2007, was battling to remain open due to insecurity of tenure, although the quality and importance of its service was widely recognized by the local police, health and judicial services. Finally in December, after an international campaign in support of its work, the shelter received funds from the national government to help it secure the property which houses the Shelter.[115]

Caring for the survivors: overcoming barriers to their right to health

> "[States should work] *to ensure … that women subjected to violence and, where appropriate, their children have specialized assistance, such as rehabilitation, assistance in child care and maintenance, treatment, counselling, and health and social services, facilities and programmes, as well as support structures, and should take all other appropriate measures to promote their safety…"* [116]

> "[P]*rogrammes to combat AIDS should give special attention to the rights and needs of women and children, and to the factors relating to the reproductive role of women and their subordinate position in some societies which make them especially vulnerable to HIV infection".*[117]

A prompt and effective state response to reports of violence against women is critical to ensuring that women do not continue to remain at risk of further violence or jeopardy to their

[110] Interview with the Department of Social Development, Victim Empowerment Programme, Pretoria, by phone 27 February 2008; http://www.info.gov.za/speeches/2002/020305146p1001.htm regarding opening of Louieville centre in March 2002.
[111] http://www.capegateway.gov.za/emg/directories/facilities/47960. Accessed on 11/02/2008.
[112] Information provided to AI in meeting with POWA, Johannesburg, 30 October 2006. See http://www.powa.co.za and http://womensnet.org.za/pvaw/organisations/powa.htm
[113] Interview with the Department of Social Development (as above).
[114] http://www.powa.co.za/Display.asp?ID=25; AI meeting with POWA, Johannesburg, 30 October 2006.
[115] Personal communication to AI from the shelter coordinator, 6 January 2008; interview with the Department of Social Development (as above).
[116] UN General Assembly (1993). Declaration on the Elimination of Violence against Women. A/RES/48/104, 20 December 1993, article 4(g). Available at: http://www.un.org/documents/ga/res/48/a48r104.htm. See also the similar requirements in Protocol to the African Charter on the Rights of Women in Africa, Article 4 (2)(f).
[117] Committee on the Elimination of Discrimination against Women (CEDAW). General Recommendation 15. Available at: http://www.un.org/womenwatch/daw/cedaw/recommendations/recomm.htm.

health or psychological well-being. Exposure to sexual violence is associated with a range of immediate and longer-term health consequences for the victim. Comprehensive care must address the following issues: physical injuries; pregnancy; STIs, HIV and hepatitis B; counselling and social support; and follow-up consultations.[118] Implementation of effective methods of screening for intimate partner violence would also assist the health sector response to women arriving at primary health care facilities and hospitals and requiring a range of medical and non-medical interventions.[119] In addition the health sector has to contribute to fulfilling the state's human rights and legal obligations to investigate crimes of violence against women, including by conducting a full medical-forensic examination with the consent of the survivor and ensuring the safe chain of custody of evidence to the police investigators.

TK's story

TK had been raped when she had gone to meet a friend on an evening in March 2006.[120] She managed to get to the police station in the area of Mpumalanga where she lived, but found the station closed. She returned at 7 am the next day. A male police officer took her statement in the public charge office. He asked her what she was wearing at the time of the rape and what she was doing out late at night. He then alluded to her complaint of being raped as another example of 'this Zuma thing', indicating to her that he believed she was making a false allegation.[121] The police did not take her to the nearby hospital, but asked her to return the following day. When she did, they took her, not to the hospital, but to the surgery of a district surgeon (General Practitioner) some 35 kms away. TK told AI that she was alone with the doctor when he examined her. *"I was crying during the examination and did not feel comfortable"*, she said. *"I did not feel confident about what he did…He did not tell me anything"* about what he was doing. *"He did not take my history…He just did a* [genital] *examination with his hand."*

He completed the police J88 medico-legal evidence form. The whole visit had lasted 10 to 15 minutes, she said. The police then drove her back to the police station, where she waited for an NGO support person who took her to the nearby hospital. There she was examined again by another doctor. He did not check her for the presence of STIs or provide emergency contraception, she said, although he did refer her for an HIV test. She declined to take the test as she already knew her positive status. Fourteen months later there had been no progress in the criminal case. She told AI that she feared this may be because the perpetrator, whose brother was a "well-known businessman", was related to a senior officer at the police station.

The story of 22-year-old TK is indicative of continuing practices which undermine women's access to adequate health services and emergency care and jeopardise women's access to justice. As described to AI, TK had been failed in almost every aspect of the state's response, with the police showing negligence in failing to take her promptly to the nearest hospital, instead subjecting her to a 24-hour delay and a long drive to the surgery of a district surgeon. Such lengthy delays can add to the distress of the survivor as she is expected not to wash or change her clothing until after the forensic examination. When TK saw the doctor, he

[118] WHO (2003), p.63.
[119] Halpern LR et al (2005); Bair-Merritt MH et al (2006); AI interview with DOH Western Cape and University of Cape Town Department of Forensic Medicine, 11 May 2007.
[120] Interviewed on 5 May 2007 without an interpreter.
[121] See above note 84 regarding the trial of Jacob Zuma on a charge of rape.

in turn failed to conduct a comprehensive examination or show any sensitivity to the complainant's state of mind or ensure the presence of a female support person.[122] Later she had to undergo a second medical examination, but still without receiving comprehensive care or treatment. The conduct of the police in this case jeopardised the integrity of the investigation and the availability of forensic evidence for the criminal investigation.

A more mixed experience of the health response was described to AI by SW, who had been abducted from her home and raped in August 2006. She described to AI that she had had to wait at the hospital for six hours before she was seen by a doctor, possibly as a consequence of the doctor also carrying other medical duties to which the hospital gives greater priority.[123] When she was finally seen, the doctor spent less than 20 minutes with her and did not take her history, although she did explain some of the steps she took in the examination procedure. SW was pregnant at the time of the rape and subsequently miscarried. She was also HIV-infected and apparently not referred to HIV clinical services. As of May 2007 no-one had been arrested in connection with the rape. Several other interviewees who had been taken to hospitals by police soon after reporting having been raped were seen after shorter intervals and appeared to have had full examinations and been offered screening and treatment for STIs and to prevent pregnancy.

These diverse experiences of the health care response to rape occurred in a context of some five or more years of initiatives by the National Department of Health (NDoH) and other government agencies to give priority to improving services for survivors of rape and other sexual offences, and to improve coordination between the criminal justice sector and health care providers in the investigation of crimes of violence against women.[124] A number of expert organizations which had reviewed, in co-operation with the NDoH, existing "sexual assault services" in the country's hospitals, concluded that there were "many systemic problems". Their 2003 report noted that these service failures were in respect to both the medical care and treatment aspect of the response and the medico-legal examination procedures for criminal justice purposes.[125]

The problems they identified were not experienced uniformly across the provinces, according to the review. For instance, the availability of a private examination room ranged from less than six per cent of facilities in the Northern Cape to nearly all facilities in KwaZulu Natal. The availability of a working angle lamp, which is a basic prerequisite for conducting a sexual assault examination, ranged from under a fifth of examination rooms in the Eastern

[122] AI had received complaints about this same district surgeon during visits in 2003 and 2004 and was informed by support organizations that the police seem to prefer to take rape complainants to this particular doctor "because he is quick".
[123] Interviewed on 6 May 2007 with the assistance of an interpreter.
[124] There has been a progressive move in recent years to shift the location of medico-legal services in rape cases away from a reliance on district surgeons (general medical practitioners with medico-legal duties) to developing capacity among medical staff of public hospitals. There have been long-standing criticisms of the district surgeon system (HRW, (1995), pp.96-98; HRW (1997)).
[125] Christofides N et al (2003). The organizations involved in the research for this report were: Gender and Health Group of the Medical Research Council, the Women's Health Project and the Centre for Health Policy at the University of the Witwatersrand, the Department of Forensic Medicine at the University of Cape Town, and the Rural AIDS Development Action Research (RADAR) School of Public Health at the University of the Witwatersrand.

Cape to all facilities in North West and KwaZulu Natal provinces.[126] In six of the provinces none of the facilities had police Sexual Assault Evidence Collection Kits which meant that patients presenting first at those facilities would have to wait for the police to bring them to the hospital.[127] The doctors interviewed in the study frequently mentioned the lack of training in the use of the Kits and some complained that the examination took too long when they did use them.[128] Indeed the study noted that only a quarter of health care providers had received any relevant training on sexual assault management; and little attention had been paid in that training to addressing provider attitudes, the psychosocial aspects of sexual assault or gender issues. A high proportion of the interviewed health care providers had no relationship with NGOs or social workers for possible referral of patients for counselling and other psycho-social support; and about a third of them described their relationship with the police as "poor".

Medical and psychological needs following sexual assault
- HIV pre- and post-test counselling, testing and post-exposure prophylaxis (PEP) where medically indicated;
- Diagnosis and treatment of any sexually transmitted infections (STIs);
- Detection and treatment of assault-related injuries to any part of the body;
- Emergency contraception, pregnancy testing, termination or management of pregnancy;
- Response to mental health problems (including post-traumatic stress disorder, anxiety and depression);
- Advice and support on intimate relationships;
- Support if a formal police complaint is to be made.

(Adapted from WHO (2003), *Guidelines for medico-legal care for victims of sexual violence)*

The report on the review of the state of post-sexual assault services emphasised the urgent need for the Department of Health to finalise and implement policy guidelines, standardised treatment and care protocols and the training of health care providers to ensure a holistic response to the patient's needs, as well as an effective medico-legal response.[129] In the four years since the study was published some progress has been made in the achievement of these goals. AI was informed in May 2007 that in the past 18 months at the national level there has

[126] Christofides N et al (2003) p.12. Based on the standard of the "Thuthuzela Care Centre" at GF Jooste Hospital, Western Cape, the basic check list of equipment required for conducting an examination includes an examination couch, working angle lamp, table, lockable cupboard for safely storing the completed evidence Kits, drug cupboard with treatment required for post-rape care and emergency clothing (Ibid, p.5). The WHO (2003) *Guidelines* add to this list washing facilities and emphasise the importance of a lockable door for the examination room to ensure privacy (pp.22-27). The Thuthuzela centres are 'one-stop' 24-hour centres in public hospitals which integrate medical, police and legal responses to rape and other sexual offences. The centres fall under the National Prosecuting Authority's Sexual Offences and Community Affairs Unit. There are a number of such centres in at least five provinces. (Information provided to AI by the DoH Western Cape, Cape Town, 11 May 2007. See Martin LJ (2002), p.121; UNICEF (2006) p.16; http://www.info.gov.za/aboutgovt/justice/npa.htm; http://www.unicef.org/southafrica/hiv_aids_998.html).

[127] However with the exception of the Eastern Cape, the vast majority of rape victims went first to the police station, according to the testimony of the health care providers interviewed for this study (Christofides N et al (2003), pp.15-16, Table 10). Where patients did present first at the hospital a high proportion of health care providers reported that they would send the patient first to the police before examining them.

[128] Christofides N et al (2003), pp.13-14. The doctors referred to examinations which took up to an hour. A "thorough examination" should take "at least two hours" (p.14). The WHO (2003) *Guidelines* states that the "physical examination of sexual assault victims must be thorough; it will inevitably be intrusive and time consuming" (p.30).

[129] Christofides N et al (2003), p.39 .

been improved co-ordination of work relating to clinical forensic medicine within the NDoH and with the provincial departments of health, to ensure effective implementation of the national plan governing the management of sexual assault and other cases of assault such as in domestic violence cases.[130] The effort to develop a national level training programme had also been recently reinvigorated. However the overall delay in developing and implementing a national-level clinical management protocol and training programme has meant that where provincial departments of health have had no effective leadership on this issue, then virtually nothing has been done.

Simelela clinic, Khayelitsha, Western Cape

In February 2000, the humanitarian agency Médecins Sans Frontières (MSF) and the Health Department of the Province of the Western Cape started a comprehensive service for people living with HIV in the informal settlement of Khayelitsha, southeast of Cape Town. In May 2001 this site became the first public sector site to provide antiretroviral therapy (ART) in South Africa for people living with HIV and AIDS. MSF subsequently was a partner in the creation of the Simelela clinic – a centre for survivors of rape – along with Rape Crisis, Treatment Action Campaign, Nonceba Counselling Service and a number of government agencies.

In August 2005 Simelela was launched as an acute one-stop centre for rape survivors in Khayelitsha. It provides comprehensive 24 hour services to victims of rape, including emergency medical care and follow up, psychological and social support, forensic medical examination and support for the patient in following up with a formal complaint to the police.

The centre, which AI visited on 10 May 2007, offers a 28-day course of PEP antiretrovirals to reduce the risk of the transmission of HIV for those who come to the clinic within 72 hours of the rape. Rape survivors who discover they are already HIV-infected are referred for ongoing treatment including ART if needed. Management of other sexually transmitted infections is also provided in the centre. Emergency contraception is given to those who want it to prevent unwanted pregnancies. Those who come to the centre too late to benefit from emergency contraception are provided with information about different options. Counselling services are available to help people cope with the psychological impact of rape. Simelela has been involved in raising awareness about rape, the need for testing for HIV and prevention of infection through education and the provision of PEP.[131]

Some provincial departments of health, in association with university departments and NGOs, have undertaken important initiatives to improve the level and integration of services for rape survivors. In the Western Cape, for instance, the Department of Health developed a comprehensive policy on the clinical and forensic management of survivors of rape and sexual assault in partnership with a "provincial reference group". The latter consisted of public health care workers, gynaecologists, forensic pathologists, psychologists, health managers, NGOs and legal advisers.[132] The consultation process began in 1999 and was motivated by the recognition that "violence (including sexual violence against women, men and children) is one of the most pervasive and common public health problems and deserves to be prioritized in the allocation of resources and in the services available to such

[130] AI interviews with health care professionals and department of health officials in Durban and Cape Town, May 2007.
[131] See MSF (2006).
[132] The examination protocol was piloted first at Groote Schuur Hospital and then at G J Jooste Hospital's Thuthuzela Care Centre (TCC).

survivors".[133] The policy document is accompanied by a comprehensive set of management guidelines,[134] an extensive forensic examination record form, post-exposure prophylaxis (PEP) HIV-prevention treatment guidelines, and a list of "designated" health facilities in the province with capacity for a comprehensive response to rape and sexual assault cases.[135] To ensure that staff at these facilities would be able implement the policy, the Department of Health Western Cape, in conjunction with members of the reference group, also developed training modules and conducted a two-day intensive in-service training programme for doctors and nurses at each of the designated facilities.[136] A specific provincial health budget line was established to implement the policy, guidelines and training programme.

The model of the Simelela Clinic and the National Prosecuting Authority's Thuthuzela centres, as examples of integrated "one-stop centres" for survivors of sexual violence, has also been pursued in KwaZulu Natal. There the provincial Department of Health in conjunction with an NGO, the Independent Medico-Legal Unit (IMLU) and the University of KwaZulu Natal Durban, developed and implemented a comprehensive training programme and has established a number of dedicated "crisis care centres" in provincial hospitals.

A forensic nursing sister, Sr SP Mbanjwa, in the examination room at G J Crookes Hospital's Crisis Care Centre, one of the first established. © AI 2002

[133] This and the following citations are from a hard copy of the DoH Western Cape, Circular No: H 68/2006, issued on 23 June 2006, provided to AI by the DOH on 11 May 2007. The DOH distributed this policy circular and attached Guidelines to all DoH Directorates, medical facilities, relevant government departments and civil society stakeholders. This document does not appear to be available online. A much earlier version though is available (DoH Western Cape (2001).

[134] Separate guidelines are available for children under the age of 14 years.

[135] The list provides contact details and opening hours. AI was informed that the facilities were based in all four health districts and could be reached by all police stations. (AI meeting with DoH Western Cape, 11 May 2007.)

[136] The five modules are on the impact of rape, medical and forensic management, legal aspects, vicarious trauma and policy implementation (Circular No: H 68/2006); meeting with DoH, Cape Town, 11 May 2007; Martin LJ (2002), p.121.

In conjunction with this development, a decentralised training programme was conducted over a five-year period at the sites of different clinics and hospitals in the province. The training workshops had a multi-disciplinary focus, and were attended by health care professionals, justice and welfare personnel, NGOs and others involved in assisting women and children survivors of violence.[137] The Crisis Care Centres, which had begun to be established by 2002, were intended to provide a comprehensive and accessible service located within the Casualty/Outpatient Department of hospitals. The programme was intended to ensure privacy and confidentiality and a supportive environment for the patient, to minimise delays and to improve coordination with police and other necessary services. The long-term intention was for the Crisis Care Centres to be staffed by forensic nurses, with medical practitioners on call.[138] In May 2007 AI was informed that the centres had been established first at the "regional hospital level" in the province, but not all hospitals had been covered. A shortage of physical space at health care facilities was a problem, as well as the constant pressure on budget for an area of health services which had still not been given the priority it needed to receive.[139] On 11 February 2008 AI was informed by the KwaZulu Natal Department of Health that there were now 34 Crisis Care Centres and dedicated services were being provided at 50 hospitals and seven Primary Health Care Clinics.

Increasing service capacity: developments in forensic nursing

The scale of sexual violence, as well as other forms of interpersonal violence, in South Africa, along with the shortage of medical doctors, has meant that rape survivors have had difficulties in accessing adequate emergency services in a timely manner.[140] Steps to develop training programmes in forensic nursing[141] were taken initially by Dr Tromp Els from the Department of Health, Northern Cape. Various other medical forensic specialists attached to universities and provincial departments of health in KwaZulu Natal, the Western Cape and the Free State have followed suit. The University of the Free State School of Nursing offers a one-year diploma in forensic nursing,[142] and forensic nurses trained there have been placed in hospitals in other provinces. In KwaZulu Natal a three-year part-time diploma course in forensic nursing is offered by the Department of Forensic Medicine.[143] The training is in skills needed for clinical forensic documentation in a range of violence cases including rape.

One of the difficulties which emerged early on in these initiatives was the lack of specialist posts available in public health care facilities, with trained nurses quickly getting absorbed back into general

[137] See the resource book for these workshops: McQuoid-Mason D et al (2002). The 12 training modules covered four major areas: the transition to democracy and the right to health, medical law and ethics, counselling and the protection of survivors of violence, and traumatology and clinical forensic medicine applicable to sexual offences. Participants received this comprehensive resource book which attached a series of documents, forms and management guidelines to assist participants in their ongoing work after the workshop.
[138] Akoojee S (2002).
[139] AI interview with University of KZN (UKZN) Department of Forensic Medicine and DoH-KZN, Durban, 9 May 2007.
[140] Christofides N et al (2003).
[141] In the 1990s the potential role for nurses in a forensic context was given recognition by the American Association of Forensic Sciences, which acknowledged it as a discipline in 1991. In 1992 the International Association of Forensic Nurses (IAFN) was established and has since acted as a voice for forensic nursing. It is strongest in North America though it is developing elsewhere including in Africa. (Lynch VA et al (2006), pp.593-604). See also Lynch VA (1991).)
[142] University of the Free State, Faculty of Health Sciences, School of Nursing. Qualification in Forensic Nursing. http://www.uovs.ac.za/fac/health/registerednursing/ForensicNursing.doc
[143] Information provided to AI in a meeting with UKZN Department of Forensic Medicine and DoH KZN, Durban, 9 May 2007.

nursing duties. Where posts have been created, the forensic nurses find that their work is not understood and there is pressure on them to undertake other duties. In addition doctors can be reluctant to relinquish to forensic nurses the responsibility of conducting the sexual assault examination and completing the police J88 form, tasks for which they are trained.[144] There remained also a lack of clarity over the recognition of forensic nurses as expert witnesses in criminal proceedings against accused in rape trials, although there appeared to be no basis in law for their exclusion.[145]

During a visit to Church of Scotland Hospital in Tugela Ferry, KwaZulu Natal, AI spoke with a forensic nurse who is the Crisis Care Centre manager at the hospital. She informed AI that the centre was working well, with patients sometimes self-referring or others being brought in by the police. Their Crisis Care Centre was seeing about 10 to 15 cases of rape and "child abuse" per month. Of the 13 cases seen in April 2007, two of the survivors were already HIV-infected at the time of testing. The "rapid test" was done in all cases and those who were HIV negative received PEP in the same visit. The supply of police Sexual Assault Examination Collection Kits for the Centre had been working well for the last two years. One of the medical practitioners on call for the 24-hour duty roster told AI that he did the sexual assault examinations, with the assistance of the forensic nurse. While she had not been called to court as a witness so far in any criminal trial, he had been called to court only once in the past three years to give expert evidence, as "very few cases" appeared in court. [146]

Improvements clearly have taken place in recent years in some provinces in the provision of training and policy guidance for medical staff and the delivery of clinical and medico-legal services in sexual assault cases. AI did, however, receive some indications of continuing problems which arose from police failures to liaise properly and urgently with medical services or the unwillingness or inability of some doctors to provide sufficient time and care to rape survivors[147] or to provide effective and authoritative medical documentation in rape cases. A related problem reported to AI were the months-long delays in provision by the police forensic laboratories of analysis results of DNA samples secured through the medico-legal examinations, with a consequent serious effect on the integrity and timeliness of the criminal justice process.[148] The response of the health care services, including in their liaison with police, appeared to be most effective where "health care providers…have received special training in managing patients after rape and understand what rape means for patients"[149], and there is strong and consistent liaison by both police and health services with psychosocial support for survivors, whether from government or NGO SPO sources. AI's observations and information received during its visit in May 2007 suggest that consistent liaison with and availability of support services remains a major problem.

In April 2007 a coalition of 25 organizations, known as the National Working Group on Sexual Offences, made a submission to the South African Human Rights Commission on poor

[144] Interview with UKZN Department of Forensic Medicine and DoH KZN, Durban, 9 May 2007; interview with University of Cape Town Department of Forensic Medicine, Cape Town, 11 May 2007.
[145] Interview with Community Law Centre, University of the Western Cape, Cape Town, 11 May 2007.
[146] Interview with medical staff, Church of Scotland Hospital, Tugela Ferry, 8 May 2007.
[147] Christofides N et al (2006) concluded from their analysis of respondents in their survey of post-rape service provision in different health care settings that users of those services highly valued having a "sensitive health care provider who could provide counselling" (p.4); see also Rasool S et al (2002), pp.89-97, on the greater weight given to the importance of counselling and support for rape survivors.
[148] Information provided to AI by forensic medical sources in KwaZulu Natal and the Western Cape, May 2007.
[149] As noted by Christofides N et al (2006), p.4.

delivery of services for rape survivors in public health facilities mainly in Gauteng province, but also in Limpopo, North West and Free State provinces. Their concerns included some of the same issues which had been raised in the 2003 published review of services noted above. These problems included health care workers displaying "unsympathetic, judgemental and impatient" attitudes; less than a third of practitioners having received relevant training; long waits; a shortage of police Sexual Assault Examination Collection Kits; and less than half of the facilities surveyed having a private examination room and a near total absence of washing facilities. They also recorded complaints of discrimination against gay men and lesbian women reporting rape.[150]

Reducing the risk of HIV transmission: The provision of post-exposure prophylaxis (PEP)

PR's Story

PR, aged 23, was raped in 1999 when she was 15 by eight boys.[151] She was abducted from a funeral night vigil she was attending. '*I did not go to the police or the clinics, even my granny* [with whom she was staying at the time] *did not know I was supposed to go to the clinic*,' she told AI. She knew some of the perpetrators and some people observed the rape but did not try to stop it, or help her. '*I was sick for one month. My granny asked the neighbours for Panadol* [a brand name for a paracetamol preparation].' After she recovered, she saw the perpetrators in the community, and '*they used to laugh at me. The boys who raped me were at secondary school, and I was at primary. Everybody knew about it and they laughed about it.*' After the death of her grandmother PR moved back to her parents, but '*they did not take care of me*,' she said, and she was unable to finish school due to a lack of support.

In March 2006 PR was raped again, this time by three strangers, on her way home during evening hours. She told her parents and spent the night at home. In the morning she went to the local police station and reported the assault. Her statement was taken by a female police officer, in the presence of an NGO lay counsellor. The police station she attended had a designated victim support centre (a room providing services and space for survivors). The police woman took her to hospital where she was able to see a doctor within 30 minutes. The doctor conducted a medico-legal examination, collecting and storing forensic specimens, using the SAEC Kit. PR was counselled and took an HIV test. The doctor then provided her with a seven-day 'starter pack' of PEP drugs to reduce the risk of HIV transmission, as well medication for STIs and emergency contraception. For the duration of her hospital visit PR had the support and advice of an NGO lay counsellor. Due to financial problems she was only able to return to the hospital after two weeks to collect her HIV results, one week after her PEP medication ran out. The result from the test undertaken two weeks earlier was positive. The doctor discontinued the PEP treatment.

Rape puts women at increased risk of HIV infection. In view of this risk and after considerable public debate and pressure,[152] the government authorised in 2002 the provision

[150] The submission was made in the context of planned hearings by the South African Human Rights Commission into the "availability, accessibility, acceptability and quality" of health services. The organizations preparing the submission included Childline, the Teddy Bear Clinic, POWA, TLAC and RAPCAN (Kerry Cullinan, "Many obstacles to health care for rape survivors," 28 April 2007, at http://www.health-e.org.za/news/easy_print.php?uid=20031644; interview with TLAC, Johannesburg, 14 May 2007; interview with RAPCAN, Cape Town, 11 May 2007. Available at: http://www.sahrc.org.za/sahrc_cms/publish/printer_246.shtml .

[151] Interviewed by AI with the assistance of an interpreter, 6 May 2007.

[152] Prior to April 2002 the Minister of Health and National Department of Health would not permit the use of PEP in public health facilities (although some provinces such as the Western Cape found a way around this prohibition) and a number of

in public health facilities of antiretroviral medication, referred to as post-exposure prophylaxis (PEP), to reduce the risk of transmission of the virus.[153] The current NDoH policy states that all survivors of rape should be offered an HIV antibody test[154] with pre-test counselling and written consent. Where medically indicated and if the patient is seen within 72 hours, they are offered PEP, along with counselling on the potential risks of HIV transmission, and on the relative efficacy and the side effects of the ARVs, as part of post-sexual assault clinical management procedures.[155] The PEP ARVs must be taken for 28 days to be most effective. An expanded drug regimen is used if the clinician assesses that there has been higher risk exposure, for instance, where multiple perpetrators were involved, or anal penetration, or the victim sustained injuries to the genital area or the HIV status of the perpetrator(s) was known.[156] According to department of health policy, if the rape survivor refuses to report an incident of sexual assault to the police, this decision does not preclude access to ARV-PEP services.[157] The clinical management of rape survivors at risk of HIV transmission also requires a number of follow-up visits and tests, including for evidence of sero-conversion. While the implementation of this policy on the provision of PEP as part of post-sexual assault services since 2002 has not been uniform throughout the country, there has been an improvement overall in access to services in the past five years.[158]

Although the offer of a test may need to be delayed for 24 to 48 hours in cases of severely traumatised or injured survivors,[159] the earliest possible confirmation of a test result appears to have important consequences for both clinical management and the survivor's ability to obtain the greatest benefit from the PEP treatment. There are currently different types of tests available. The most accurate are provided in specialised laboratories. However these take a minimum of several days for results to be available, requiring the tested person to return to

doctors and NGOs were harassed and subjected to disciplinary proceedings for taking steps to assist patients in the public health sector. However under pressure the government at Cabinet level made a decision to allow the offer of PEP in public facilities at a pace to be determined by the provinces. South African health care professionals, SAMA and many NGOs including ALP, CADRE, CSVR and support organizations such as GRIP and Rape Crisis lobbied for a change in government policy. See also Smith C (2001); Amnesty International (2002); Amnesty International, Human Rights Watch (2003). In November 2001 Amnesty International sent a nine-page communication to the National Minister of Health and the provincial MEC for Health: Mpumalanga appealing to them to respect international human rights standards, medical best practice and the professional ethics of health care providers who were being subjected to harassment as a consequence of their efforts to assist rape survivors, including through the provision of PEP.

[153] Christofides N et al (2006), pp.36-40 on the relative risks of HIV transmission and the efficacy of PEP interventions in averting transmission. See also Centers for Disease Control and Prevention (2005). NDOH Policy Guidelines for management of transmission of HIV and STIs in sexual assault, Available at: http://www.doh.gov/aids/index.html

[154] If antibodies against HIV are found, i.e. the test result is positive, this means the person is carrying the virus. For a person to test HIV-infected, he or she needs to be infected for six to twelve weeks, the time period it takes for the body to produce a detectable amount of antibodies. This period, when the virus cannot be detected, is known as the 'window period'. The patient should also be tested for Hepatitis B.

[155] National Department of Health (2003). [The Document is undated but filed on the NDOH website under 2003 files.] Akoojee S et al (2005), pp. 63-71; PEP Treatment Guidelines, DoH Western Cape, Circular No: H 68/2006, 23 June 2006.

[156] See also Denny L (2002); Christofides N et al (2006) pp.36-38.

[157] Akoojee S et al (2005), p.65; NDoH (2003).

[158] Christofides N et al (2006), p.7. In their report published in 2003 on their assessment of post-sexual assault services, the MRC and others noted that although PEP was not then available in public sector hospitals (with exception of the Western Cape), between nearly a third to four-fifths of provincial hospital doctors or providers were advising patients on this treatment and a minority of them were providing it through private prescriptions and in co-operation with NGO support organizations (Christofides N et al (2006), pp. 26-27, Table 21). AI observed during visits to a number of provinces between 2002 to 2004 and in 2007 a gradual improvement in access to PEP services in public hospitals.

[159] Denny L (2002).

learn the results. The "rapid test", comprising a screening and a confirmatory test, allows for the results to be available immediately provided the two tests give the same result.[160] Those rape survivors who test negative can be provided with the full 28-day course of PEP during this initial visit. This is the practice, for instance, at the Thohoyandou NGO-run Victim Empowerment clinic in Limpopo province.[161] Some of the women whom AI interviewed may have been living with HIV for some years, but only came into contact with medical services as a result of being raped. Where the test results are available immediately, rape survivors who test positive, indicating that the patient was HIV-infected prior to the sexual assault, can be counselled on their status during the course of the same visit and then ideally should be referred to an HIV clinical programme at the same time, if they are not already part of such a programmeme. In all cases, pre- and post-test counselling should be carried out as recommended in testing guidelines.[162] People living with HIV require regular medical consultations and tests, including a CD4 count, to assess their need for treatment and care. It is therefore important that women who discover their HIV positive status as part of post-sexual assault examination and treatment are not lost to follow-up.

However, AI concluded from the testimony of several rape survivors interviewed in May that the "rapid test" was not always used. Three women who had been taken to a particular hospital in Mpumalanga province were provided with four or seven-day PEP 'starter packs', to reduce the risk of HIV infection on the presumption of their negative status. They were asked to return for their HIV test results. If negative, they would have been provided with further treatment for the remainder of the 28-day period. For various reasons they were unable to return to the hospital. One of the women, SW, had been abducted at night from the family home by a young man wearing a balaclava and wielding a large knife who raped her in a football field. She had been provided with a four-day starter pack and told to return for her HIV test results. However her employers told her she must choose between keeping her job and looking after her "problems". As she was the sole supporter for her family, she chose to stay at work and did not return to collect her results.[163] A second woman, PR, whose story is above, only managed to return two weeks later (one week after the PEP medication had run out) to collect her results. The third woman, SS, who had been provided with the seven-day pack in October 2006 and asked to return within three days to collect her results, had still not gone back to the hospital seven months later. She told AI that this was due to her having no money for transport and feeling unwell.[164] The impact of costs and distances on treatment adherence was evident in another case, involving a 15-year-old girl whose mother tried to get her to a clinic 48 hours after being raped. They travelled from their rural home in Limpopo province by public taxi for two hours, only to find that the clinic had closed at 4 pm. An NGO support worker managed to get the young woman seen at a hospital where she was examined,

[160] If there is a discrepancy in the rapid test results, then additional laboratory testing (e.g Western Blot) has to be done. See Branson BM (2003); WHO (2004); Akoojee S et al (2005), p.28; and Greenwald JL et al (2006). Tests giving a weak positive reaction need confirmation with laboratory tests. See Gray RH et al (2007). Laboratory testing remains the definitive diagnostic and quality control tool.
[161] Christofides N et al (2006), p.21.
[162] WHO (2004), pp.34-41.
[163] Interviewed by AI on 6 May 2007 with the assistance of an interpreter.
[164] Interviewed by AI on 6 May 2007 with the assistance of an interpreter.

tested and provided with a seven-day starter pack of PEP. However she was unable to return to collect her test results or further PEP medication.[165]

In KwaZulu Natal, the information provided to AI indicated that the practice is to use the rapid test and provide the 28-day treatment at the initial visit, although AI heard of one case where the survivor was asked to return to the hospital for her results, possibly because of discordant tests or other uncertainties.[166] According to the Western Cape DoH Guidelines, "rapid HIV testing should be made available *where feasible* and offered to patients *who request it*" (emphasis added). The HIV enzyme immunoassay (EIA) laboratory test appears to be the routine offered test, with the results provided three days later, during which period the survivor had been provided with a three-day PEP starter-pack. If negative, the woman is provided with a weekly supply of PEP drugs, at each of four weekly follow-up visits. The purpose of these visits also includes monitoring of progress and responses to the drugs.[167] It is not clear why the rapid test was not more routinely available in public health facilities or why the onus would be left to the patient to request it, particularly in circumstances where the tested person may not return to learn the test result.[168]

As appears from the testimonies of the three women above and the story of the young rape survivor from Limpopo province, the necessity to return to the hospital imposed additional financial burdens and emotional strain for them. Their inability to return or to return in a timely manner also could jeopardise the effectiveness of any treatment regimen.

According to information provided to AI in May 2007, relatively few patients who are initially provided PEP starter packs return to the clinic for their HIV test results or to receive further treatment. The Western Cape DoH, for instance, stated that the number of patients who complete the 28-day full treatment is "not high", while the Medical Research Council put the figure at a low 15 per cent, with considerable attrition over the four week period of scheduled return visits. Most of the patients who did not finish the treatment had stopped taking it by the end of the first week.[169] This is in contrast with an 87 per cent completion rate for the Thohoyandou centre in Limpopo (see further below). In recognition of possible obstacles to patient return visits and adherence to treatment, the Western Cape's Treatment Guidelines do recommend that "for those who cannot return for a one-week assessment due to

[165] Information provided to AI in a meeting at AIDS Law Project, Johannesburg, 30 October 2006.
[166] Information provided by DoH KZN, Durban, 10 May 2007 and reconfirmed by the DoH KZN on 11 February 2008 that the 28-day pack is used routinely. AI interview with an SPO concerning shelter clients, 10 May 2007. However Akoojee S et al (2005) add that "to avoid delays in starting PEP, starter packs of recommended drugs should be available in all health care facilities", p.69 (pending confirmation of test results).
[167] PEP Treatment Guidelines, Department of Health Western Cape, Circular No: H 68/2006, 23 June 2006; Christofides N et al, (2006), pp. 20, 23.
[168] Apart from the example given above of the Thohoyandou centre, AI observed that the rapid test was available to one SPO whose staff member, a retired nurse, used the rapid test to conduct three and six-month follow up tests for sero-conversion with rape survivors at venues convenient for the latter.
[169] Interview with the DoH Western Cape, Cape Town, 11 May 2007; interview with Medical Research Council, Pretoria, 14 May 2007; Christofides N et al, (2006), pp. 5, 18, who also cite other studies indicating low completion rates in different parts of the country. See also Human Rights Watch (2004).

logistical or economic reasons, a one-month supply should be given". This appears consistent with national DoH policy.[170]

Researchers who conducted an in-depth study on the effectiveness of provision of PEP services in two different types of health care settings concluded that the high PEP completion rate in the Thohoyandou NGO-run centre was primarily due to "the home follow-up service provided by the [NGO] [which] sought to meet clients' needs for emotional support in the period after the rape, to reinforce information about medication after the immediate trauma when recall is better", as well as to promote adherence to treatment.[171] They also provided food supplements during the home visits and referred a higher proportion of their clients for counselling. The centre routinely used the rapid test and, where a negative result was obtained, provided the full month course of PEP drugs to the survivor at the first visit. However in a situation where the centre's health care provider assessed that the "secondary trauma caused by the receipt of the HIV test result [would be] greater than the woman could bear at that time", the survivor would be given a three-day starter pack and a bus ticket, enabling the woman to return to the centre three days later.[172]

The Criminal Law (Sexual and Related Matters) Amendment Act , which was signed into law by President Mbeki in December 2007, confirms the right of a "victim exposed to the risk of HIV" to have access to PEP. The right, though, is subject to the victim having either laid a charge with the police in respect of an alleged sexual offence, or reported such an incident at a "designated health establishment". The new law sets out a process for identifying and circulating a list of "designated health establishments". Administrative delays or poor communication practices at provincial level could, however, result in additional hurdles for survivors of rape who must reach a designated centre within 72 hours.[173] Every police station, health care facility or other referral agency would need to have the most current lists at hand for the advice and urgent referral of victims, in order for this provision to be effective. The designated centres would also have to be accessible on a 24-hour basis. During parliamentary hearings on the draft law in late 2006, advocacy organizations had raised their concern about the intention to confine state-provided PEP services in this manner, fearing that it would further limit access to the treatment.[174] In addition the new law's complex provisions allowing a complainant to seek a compulsory testing order for an alleged assailant during a period of 90 days after the assault have been criticised as not necessarily in the best interests of the

[170] The NDoH Guideline is similar to the DoH-WC guideline, recommending a one week supply unless there are reasons to provide a full 28 day course. See National Department of Health (2003). However there is an indication that this policy may have been changed in 2005, according to information provided to AI by the Medical Research Council, Pretoria, 14 May 2007.
[171] Christofides N et al, (2006), p.5. The study was undertaken at the Thuthuzela Care Centre, which is attached to a secondary level hospital in Cape Town Metropole and is accessible 24 hours per day seven days a week, and Thohoyandou NGO-run Victim Empowerment clinic, which is attached to Tshilidzini district hospital.
[172] Christofides N et al (2006), p. 21.
[173] As noted above, the DoH-Western Cape has such a list and has circulated it widely. KwaZulu Natal would also be in a reasonable position to respond to these requirements on the basis of its Crisis Care Centre system. Not all provinces, including Mpumalanga, would be in this position though.
[174] The parliamentary submission on this and other concerns was made by Women's Legal Centre, the Centre for Applied Legal Studies, Molo Songololo, Rape Crisis, SWEAT, RAPCAN, ALP and Gender, Health and Justice Research Unit (IOL, 9 July 2007). See also Combrinck H (2006).

complainant, apart from other considerations concerning the rights of the person to be tested.[175]

On the basis of the above research findings and AI's own inquiries, an effective health sector response to the risk of HIV transmission from rape appears to need an approach which takes into account the economic disadvantage of many rape survivors, the barrier to access posed particularly for rural women by the distances from health care centres offering PEP services, and the need for continuing emotional support for many rape survivors well beyond the initial days of contact with state services. There has been a longstanding shortage of qualified psychologists and social workers based in public hospitals.[176] The burden of this vital counselling and other follow up work appears to fall mainly on a number of non-governmental service providing Organizations (SPOs). AI is familiar with the work of some of these deeply-committed and knowledgeable organizations in different provinces of South Africa. Their funding may, but does not always, extend to the provision of field workers for home visits, or include budget to support the transport needs of survivors. In addition their access to continuing funds for their work is always uncertain and cannot be the basis for the state discharging its human rights and other obligations towards the survivors of gender-based violence. This service gap requires urgent attention from the relevant government departments.

[175] The new law, for instance, obliges the police investigating officer to inform the complainant of the results of the compulsory test order. There is concern that this is an inappropriate responsibility for the police and that the complainant could experience the potentially traumatic impact of the results without psychosocial support or the advice of health care professionals. On the broader issue of compulsory testing and the rights of suspects, see Cameron E (2007), Patrick M. Eba (2007).

[176] NGO SPOs and medical staff involved in providing post-sexual assault treatment and care at hospitals have mentioned this concern during meetings with AI in 2003, 2004 and 2007.

3. Gender-based discrimination as a barrier to prevention, treatment and care for HIV

"Women are afraid. They will allow [their husbands] to sleep with them without condoms [because] they are afraid that their husbands won't maintain them or stay with them." (Testimony of NO, a woman living with HIV in rural Mpumalanga)[177]

"I am at the lowest end of all."[178](Testimony of TH, a woman living with HIV in rural KwaZulu Natal, describing her position in the household of her husband's family)

Violence against women is a persistent and devastating manifestation of gender-based discrimination which can place women at risk of HIV. However, as explored in this chapter, there are other forms of discrimination in the social and cultural spheres which can also act as barriers to women's access to prevention, treatment and care for HIV. There has been extensive transformation since 1994 of the legal framework to entrench gender equality, protect women's sexual and reproductive rights and their right not to be subjected to violence. However, the rural women whom AI interviewed were continuing to experience oppression in their relationships with male partners, within families and in the wider community as a result of their low social status, economic marginalisation, and also in some cases because of their HIV status. These manifestations of their inequality as women were associated with a range of consequences, including abandonment, loss of their homes, failure to complete their education, inability to secure maintenance for their children, violations of their sexual and reproductive rights with an associated increased risk of HIV infection, and barriers to access to HIV-related health services and treatment adherence.

Legal Framework

By the end of the first decade of the new democracy South Africa had transformed its national legal framework affecting women's rights, and had become a state party to all of the key international human rights instruments intended, among other things, to:

- promote and protect women's right to equality with men and in the political, public, cultural and private spheres and before the law,
- ensure the elimination of all forms of discrimination against women including in relation to access to education, health, housing and employment,
- protect their sexual and reproductive rights, and their right to freedom from all forms of violence and abuse.[179]

[177] Interviewed on 5 May 2007, with the assistance of an interpreter.
[178] Interviewed on 7 May 2007 with the assistance of an interpreter.

This transformation had been undertaken in a context in which "the legal and economic edifice of apartheid had, both in the public and private realms, generated and reinforced discrimination against, and dispossession and subjugation of, women."[180] Gender-based discrimination was inherent in both civil and customary law. Predominantly rural black women, who lived under both legal systems, "were always under the perpetual tutelage of a male, whether their father, husband or even a son."[181] The Minister of Justice, in introducing legislative reforms in parliament in 1998, commented that his objective was "to create real equality for women…who for decades…have been regarded as inferior, with no right to hold property in their own name…and who, generally speaking, have been the subjects of domination".[182] Black women had also experienced decades of racial and political oppression which restricted their enjoyment of a wide range of internationally recognized human rights. The Pass Laws, "homeland" and migrant labour system had had severe personal, social and economic effects on the lives of these women, through, for instance, enforced and prolonged separations of family members, confining the majority of women with their children to economically unsustainable rural areas or limited, poorly paid urban-based work, and punishing infractions of influx control laws with 'deportations', fines or imprisonment.

Against this background of the urgent need for transformation, a coalition of women's organizations fought successfully in 1993 to place on the agenda of the Multi-Party Negotiating Process the need to include in the draft constitution the principle of non-sexism, a strong equality clause which would prohibit gender discrimination and the inclusion of customary law and traditional authority within the ambit of the Bill of Rights in the Interim Constitution. They pushed hard also for the inclusion of "socioeconomic rights and reproductive rights [and to establish] a constitutional basis for affirmative action and for a widened notion of social citizenship".[183]

The resulting final Constitution, which was signed into law by President Nelson Mandela on 10 December 1996, provided in section 9(3) that:

> *"the state may not unfairly discriminate directly or indirectly against anyone on one or more grounds, including race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language and birth."*[184]

[179] See list of key international human rights treaty commitments made by South Africa in Table 1, p. 6.
[180] Andrews P (2001), p.326; see also Bronstein V (2000).
[181] Andrews P (2001), p.327; Zaal FN (1995) pp. 34-35; Nhlapo T (1995), pp.159-161.
[182] National Council of Provinces Debates (1 November 1998), cited in Bronstein V (2000), p.564.
[183] Hassim S (2006), pp.151-161; Albertyn C (2007), pp. 82-83, 90-91; Meer S (1998), pp. 142-157.
[184] The Constitution protected equality on the grounds of gender, while at the same time guaranteeing the rights of freedom of religion and the practice of culture. The latter issue was a very sensitive matter in view of the destructive impact of colonial and apartheid rule on indigenous cultures and institutions (Chanock M (1991)). The potential for conflict between these rights was resolved by creating a hierarchy of rights (Andrews P (2001), p.338; Mbatha L, Moosa N, Bonthuys E (2007), p. 165; Nhlapo T (1995), p.159.), with section 30 accordingly affirming that everyone has "the right to use the language and to participate in the cultural life of their choice, but no one exercising these rights may do so in a manner inconsistent with any provision of the Bill of Rights". This provision was strengthened by the requirement under section 39 that "When interpreting any legislation, and when developing the common law or customary law, every court, tribunal or forum must promote the spirit, purport and objects of the Bill of Rights". In addition Section 211 (3) requires that "the courts must apply customary law when that law is applicable, subject to the Constitution and any legislation that specifically deals with customary law".

The justiciable Bill of Rights entrenched a number of other rights of importance to women. Section 12 (1) (c) guarantees the security and freedom of the person which includes "the right…to be free from all forms of violence from either public or private sources". Section 12 also protected everyone's "right to bodily and psychological integrity", including the right to "make decisions concerning reproduction" and the right to "security in and control over their body".

The Bill of Rights permitted special measures to promote the achievement of equality for "persons or categories of persons, disadvantaged by unfair discrimination" under Section 9(2).[185] The fact that the Constitution also included social and economic rights, as part of the legally enforceable Bill of Rights, held potentially far-reaching consequences for women. These provisions, relating to housing, health care, food, water, social security and land rights, had the potential to provide "a basis for advancing equality and social justice for women".[186]

Following the adoption of the new constitution the South African parliament passed a number of laws as steps towards implementing the constitutional provisions entrenching gender equality, protecting women's sexual and reproductive rights and their right not to be subjected to violence. These laws include: the Choice on Termination of Pregnancy Act (92 of 1996),[187] the Employment Equity Act (55 of 1998), the Maintenance Act (99 of 1998), the Domestic Violence Act (116 of 1998), Recognition of Customary Marriages Act (120 of 1998), the Promotion of Equality and Prevention of Unfair Discrimination Act (4 of 2000) and the National Health Act (61 of 2003) which includes, under Section 2(c)(i) as an objective, "protecting, promoting and fulfilling the rights of …the people of South Africa to the progressive realisation of the constitutional right of access to health care services, including reproductive health care."

The preamble to the Promotion of Equality law highlighted the need to eradicate "social and economic inequalities, especially those that are systemic in nature, which were generated in [South Africa's] history by colonialism, apartheid and patriarchy". Section 8 of the Act prohibits "unfair discrimination on the ground of gender", including through gender-based violence; the system of preventing women from inheriting family property; any practice, including traditional, customary or religious practice, which impairs the dignity of women and undermines equality between women and men; any policy or conduct that unfairly limits access of women to land rights, finance and other resources, and to social services or benefits such as health, education and social security; and systemic inequality of access to opportunities by women as a result of the sexual division of labour.[188] This Act and a subsequent amendment established the authority of the courts to function as "equality courts" to hear *prima facie* cases of alleged unfair discrimination or other violations under the Act

[185] The Convention on the Elimination of all Forms of Discrimination against Women (Women's Convention) provides that "Adoption by States of temporary special measures aimed at accelerating de facto equality between men and women shall not be considered discriminatory…". South Africa ratified this Convention in 1995 and the Optional Protocol to the Women's Convention in 2005. It also ratified (in 2004) the Protocol to the African Charter on the Rights of Women in Africa.
[186] Hassim S (2006), p.158. See also Liebenberg S (1995), pp.82-83.
[187] This Act was amended in 2004 but the Constitutional Court ruled the resulting Act invalid. A new bill was prepared and the Choice on Termination of Pregnancy Amendment Bill [B 21-2007] was finally passed by Parliament in a special session held in January 2008.
[188] Promotion of Equality and Prevention of Unfair Discrimination Act (4 of 2000), Section 8 (a), (c), (d), (e), (g), (i).

brought by complainants.[189] However although far reaching in its implications for women's rights, it appears that few cases under the Act have been brought forward to the courts.[190]

The government's international legal obligation to promote gender equality also took institutional form. The resulting "national gender machinery" included the statutory Commission on Gender Equality, the parliamentary Joint Monitoring Committee on Improvement of Quality of Life and Status of Women, the Office on the Status of Women located within the Office of the President, and "gender focal points" within national and provincial government departments.[191]

Low social status and vulnerability to HIV infection and its consequences

Despite the transformation of the legal and institutional framework of gender relations, the lives of most of the women whom AI interviewed in rural areas of KwaZulu Natal and Mpumalanga provinces illustrated the manner in which women's inferior social status, as well as economic marginalisation, "are inextricably interwoven with the oppression women experience in the home and in many cultural…contexts".[192] As observed by a parliamentary ad hoc committee in a report in 2007 on the effectiveness of the Commission for Gender Equality and other statutory bodies, "South Africa remains a society with strong patriarchal tendencies in which women are expected to fulfil inferior, gender-based roles."[193]

The women interviewed were living in a variety of often difficult circumstances. Three of them had been abandoned by their partners because of their own HIV-infected status and nearly a third of the women had experienced the death of a previous or their only partner from AIDS-related illness. The overwhelming majority of the women, just over three-quarters of them, were living with their relatives and/or their own children and grandchildren. Very few of them received any maintenance from the fathers of their children.[194] While only three of the women were living in polygynous marriages and households, several other women reported that their husbands, who were migrant workers, had taken second wives with whom they lived when they were working away from home, a situation which reflected a long entrenched pattern of migrant labour and disrupted family life in these rural former 'homeland' areas.[195] In addition nearly a quarter of the women had experienced being "chased away" by their husbands or having felt forced to leave their homes when their husbands took a second wife or had been abandoned for similar reasons. They included KE, who had become very ill and tested positive in 2007. She had separated from her husband because he had taken a second wife and moved her into their house. *"I felt I had to leave,"* she said.[196] Only one-fifth of the

[189] See Promotion of Equality and Prevention of Unfair Discrimination Amendment Act (52 of 2002).
[190] Albertyn C (2007), pp.112-118.
[191] Hassim S (2006), pp. 210-245.
[192] Liebenberg S (1995), p.87. See also Zondi N (2007), pp. 20-28 and Hunter M (2005), pp.152-156 concerning KwaZulu Natal, and Sideris, T (2005), pp.124-135 concerning Mpumalanga. Interview with TLAC, Johannesburg, 27 October 2006; interview with WISER, University of the Witwatersrand, Johannesburg, 31 October 2006.
[193] The Asmal Committee (2007), p.147.
[194] See below chapter 5 on the difficulties women face in accessing the maintenance system.
[195] Lund F (2007), pp. 2-3; Hunter M (2005), pp.145-150.
[196] Interviewed on 5 May 2007 with the assistance of an interpreter.

women reported that they were currently sharing their lives and homes with partners whom they described as supportive and providing family income. Two amongst this group had experienced violence from previous partners.

The National Strategic Plan on HIV/AIDS for 2007 to 2011 (NSP) recognised that gender inequalities, patriarchal and other negative attitudes towards women "impact significantly on the choices that women can make in their lives" and increase the risk of their exposure to HIV.[197] These dynamics were evident in a number of the women's stories, including that of 50-year-old ES from Mpumalanga. She told AI that as a result of her husband taking a second wife, and the ensuing family conflict, she was forced to leave her marital home.[198] She had been with her husband since she was 18 years old and during the following 20 years she had raised their five children and supported the family by selling things and brewing beer. Her husband, who was a local traditional leader, had found paid work in recent years but, instead of maintaining his existing family, he used his wages to provide for a new relationship and marriage, she said. *"There was no peace, he did not maintain us…He threw out my clothes* [and] *there was conflict between my children and their father,"* ES told AI. She also blamed her husband for her illness. In 2005, after these events, ES had tested HIV-positive. She was now living with her four young grandchildren.

The consequences of low social status in restricting choices for women and placing them at risk of HIV infection was evident also in the testimony of SN, a 22-year-old woman from KwaZulu Natal. She told AI that her greatest wish was that her in-law family would stop putting pressure on her husband to take his widowed sister-in-law as his second wife. Her husband's brother had died apparently as a consequence of AIDS-related illness. He was survived by his wife, who was unwell with TB, and three young children, the youngest of whom also had TB. The widow was refusing to undertake an HIV test and SN described her in-law family as typical of the local community in not wanting to talk about the situation. Her husband, who worked in Gauteng, had come under so much family pressure on his last home visit to be with his widowed sister-in-law that he decided not to return home again. SN, who had had to leave school prematurely because of caring and other family responsibilities, had no financial resources and did not have the permission of her husband's family to visit him at his work place. She felt out of favour with her mother-in-law as well, because she had no children, whereas her sister-in-law had three children. SN became distressed when describing this family conflict and her sense of powerlessness and being disregarded within the family. *"If the situation did not change, the virus is my biggest fear, of getting it…because two of us want the same man and therefore I will end up being killed by the virus."*[199]

The NSP recognized the need to improve access to information and to legal remedies for the poor and the marginalised and to "identify and remove… cultural barriers to effective HIV prevention, treatment and support".[200] The legal reforms leading to the 1998 Recognition of Customary Marriages Act ought to have led to some of the changes called for in the NSP.

[197] NSP (2007), pp.31-33.
[198] Interviewed on 4 May 2007 with the assistance of an interpreter.
[199] Interviewed on 7 May 2007 with the assistance of an interpreter. See Zondi N (2007) on the pressures women can feel in polygynous households and related risks to exposure to HIV.
[200] NSP (2007), pp.15, 32-33, 49.

The Act provided for women's full legal status and capacity on the basis of equality with their spouse, with right of access to the courts to alter matrimonial property arrangements or in regard to divorce.[201] Human rights lawyers commenting on the impact of this legislation warned that "there is a real risk that the [protection] provisions will remain a paper solution… [as they] affect a sector of …society that has the least access to courts and the least expertise in dealing with them".[202] Indeed, the circumstances described in the stories above suggest that the provisions of the Act have not protected women, particularly the husband's first wife, from being disadvantaged or abused and being placed at risk of HIV infection. As documented by other researchers, the women felt powerless, trapped in situations of domestic conflict and without access to social or legal remedies.[203]

A 'victim-friendly' facility attached to a police station and run by the support organization, GRIP, for survivors of gender-based violence. © AI 2007

[201] Section 6 provides that "a wife in a customary marriage has, on the basis of equality with her husband and subject to the matrimonial property system governing the marriage, full status and capacity, including the capacity to acquire assets and to dispose of them, to enter into contracts and to litigate, in addition to any rights and powers that she might have at customary law". The Act laid down procedures in Sections 7 and 8 allowing the spouses jointly to apply to court for changes to be made in the matrimonial property arrangements, and requiring for all persons with a sufficient interest in the matter, in particular the male applicant's existing spouse(s) and future spouse, to be joined in the proceedings. TLAC (nd) "Recognizing Customary Marriages" (pamphlet) (Johannesburg); Mbatha L, Moosa N and Bonthuys E (2007), pp. 161, 190-191. The latter authors note also that the Constitutional Court, in separate rulings, has declared to be unfairly discriminatory and in violation of the right to dignity the customary rules of succession as also reflected in several statutory laws which exclude women and female children from acting as heirs to family property (*Bhe and Others v The Magistrate Khayelitsha and Others (*Case CCT 49/03)*; Shibi v Sithole and Others* (Case CCT 69/03) and *SAHRC and the Women's Legal Centre Trust v President of the Republic of South Africa and Another* (CCT 50/03)).

[202] Bronstein V (2000), p.562; Bonthuys E and Domingo W (2007), pp.78-79; Mamashela M (2004), pp. 616-641.

[203] Interview with WISER, Johannesburg, 31 October 2006, on conflict within polygynous households affected by AIDS-related illness in rural Limpopo; Zondi N (2007), pp. 21-24 concerning conflict within polygynous households and competition between co-wives in Kwazulu-Natal. Mbatha L, Moosa N and Bonthuys E (2007) refer to a study done by the Centre for Applied Legal Studies, University of the Witwatersrand, which noted that "[i]nterviews with wives in polygynous marriages indicate that they did not wish their children to be party to polygyny as it forced women into endless strife over a man and his resources. Younger wives claimed they were ill-treated and abused by their senior co-wives, and were expected to discharge domestic chores, while older wives condemned their young co-wives for appropriating their husbands and for being more interested in the financial benefits of the marriage than in the husbands. Senior wives wanted the law to oblige their husbands to treat all wives equally and they wanted their consent to be necessary for subsequent marriages by their husbands" (pp.178-179, 181).

Another aspect of the women's low social status was their limited educational background. Amongst eleven of the interviewees who provided information to AI on the extent of their access to education, only one had managed to complete her high school qualifications, 37-year-old ST, who was a mother of a four-year-old girl and had been living with HIV for several years.[204] She had been raising her child on her own since the death of her husband from AIDS-related illness. Despite these burdens, she told AI that she felt optimistic and well, after starting an ARV treatment programme more than a year ago, and was actively seeking paid employment as a matriculated school leaver. She had started an informal support group for others living with HIV and AIDS and was looking for other ways in which to help her community. However the other women were struggling with the consequences of disrupted education. Seven had completed various years of high school, but had had to leave for reasons including the consequences of sexual violence and harassment at school, or financial or social and family pressures. One interviewee who had been orphaned as a young child *"only went to grade two"* in primary school. Like a number of other members of this group of interviewees, 22-year-old SN expressed a wish to complete her schooling. She had stopped at the end of standard 5, she said, because she was expected to work in the fields. Her day was also taken up with child care duties, work in the fields, bringing water back to the household in containers, and caring for people sick with tuberculosis and AIDS-related illnesses.[205]

Their limited access to education, due to gender-based inequalities, the impact of sexual violence, or, for older women, the discriminatory apartheid-era education policies, contributed to their sense of frustration at their lack of autonomy and economic opportunities in their lives. As 35-year-old TH, who had not been able to finish school and could only *"write a little"*, said, *"I want to have more skills, to do more, to do 'handwork', to have an income and develop as a person. But I have no money for all of this."*[206]

The women's stories and the negative consequences of their low social status and lack of agency indicate the need for increased efforts by government to protect women's right to equality, particularly due to its impact on the enjoyment of other rights.The government's legal obligations stemming from the Constitution and international human rights law, and the commitments it has made to promote the aims of the NSP, require it to take all necessary measures to ensure that women living in polygynous marriages have access to information on their rights and to an effective remedy where their rights have been violated. The Protocol to the African Charter on the Rights of Women in Africa obliges States Parties to ensure "that women and men enjoy equal rights and are regarded as equal partners in marriage" and that furthermore, "the rights of women in marriage and family, including in polygamous marital relationships, are promoted and protected".[207] In addition, the UN Committee on Economic, Social and Cultural Rights (CESCR) has observed that the obligation of a State Party to ensure the exercise of the right to health without discrimination includes the obligation to

[204] Interviewed on 4 May with the assistance of an interpreter.
[205] Interviewed on 7 May 2007 with the assistance of an interpreter.
[206] Interviewed on 7 May 2007 with the assistance of an interpreter.
207 Article 6. (This human rights instrument has not been utilised fully in litigation or advocacy work according to Delphine Serumaga of POWA writing in Pambazuka Newsletter, 23 November 2007.) Two UN treaty bodies have referred to the practice of polygyny as "inadmissible discrimination against women" (UN Human Rights Committee, General Comment No.28, at para.24; CEDAW, General Recommendation 21, at para.14.

shield "women from the impact of harmful traditional cultural practices and norms which deny them their full reproductive rights".[208]

Access to education has been shown to be associated with the ability of women and girls to protect themselves against HIV infection,[209] and "essential for sustained and effective participation in political and economic decision making."[210] A recent published study focussed on young people in rural South Africa also found that "attendance at school may be associated with lower vulnerability to HIV".[211] The Special Rapporteur on the right to education referred to education "as the pass key to unlocking other human rights".[212] As described further below the women AI interviewed, whose education had been disrupted, also had limited access to secure livelihood, with direct effects on their ability to have access to information, prevention, treatment and care in relation to HIV and AIDS.[213] South Africa, which has obligations to progressively realize the right to education and protect the right to gender equality in and through education,[214] has made substantial progress since 1994 in addressing the legacies of the grossly unequal, racially-defined education system the government inherited.[215] This progress has included a gradual improvement in access to education for girls overall,[216] although concern has been expressed that this gain could be eroded by the disproportionate impact of the HIV epidemic on young women.[217] In addition the reports of the South African Human Rights Commission and the UN Special Rapporteur have drawn attention to the impact of poverty as a barrier to access to education.[218] Both the Protocol to the African Charter on the Rights of Women in Africa and the Women's

[208] CESCR, General Comment 14, at para.21, as noted by Cook R J, Kelly L M (2006), p.35.
[209] UNICEF (2004).
[210] Liebenberg S (1995), p.87.
[211] Hargreaves JR et al (2008), who suggested that this association may be "through an impact on the size and characteristics of the sexual network of students compared with those who leave school early". They also found that among young women, "fewer students reported having partners more than three years older than themselves". Girls with partners more than three years older than themselves are at greater risk of violence and of HIV infection, with the man more likely to have multiple partners (information provided to AI by a researcher with the Stepping Stones project in the Eastern Cape, 28 October 2006).
[212] Tomasevski K (2006); Wilson, D (2003), p.17.
[213] See Section 5 on the role of poverty and unemployment as barriers to the realization of the right to health for rural women living with HIV and AIDS.
[214] In terms of Article 29(1) of the South African Constitution which guarantees that: "[e]veryone has the right
a. to a basic education, including adult basic education; and
b. to further education, which the state, through reasonable measures, must make progressively available and accessible". As a State Party, South Africa also has obligations under Article 17(1) of the African Charter, Articles 2 and 10 of the Women's Convention, and Article 12(2) of the Protocol to the African Charter on the Rights of Women in Africa. Article 13(1) of the ICESCR, to which South Africa is a signatory, obliges States Parties to respect, protect and fulfil the "right to everyone to education". As a signatory to the Covenant, South Africa should not act contrary to the object and purpose of the treaty.
[215] See STATSSA Community Survey (2007), pp.23-29 for indications of increasing access to primary, secondary and higher education between 1996 and 2007, with however previously disadvantaged groups still far behind in respect of higher education enrolments.
[216] STATSSA Community Survey (2007) does show a consistently higher enrolment of males compared with females aged five to 24 years attending education institutions in 2001 and 2007, but the gap is small, between one to three per cent, depending on the province and the year (p.24, Table 4.1). Casale D and Posel D (2005) show from 2003 data that the gap between "African women" and "all women" in average years of education was gradually narrowing, with African women aged 20 to 24 having completed 10 years of education on average, compared with less than six years for women aged 45 to 54 years (p.23); Moletsane, R. (2007), p.156.
[217] Moletsane R (2005), pp.80-88; Leoschut L, Burton P (2006), pp. 6, 37-38, 43, 60-62, 67-73; Frank C (2006), pp.25-51; Chisholm L, September J (2005).
[218] See the comments on the poverty barrier in South African Human Rights Commission (2006), pp. 8, 19-20 and Tomasevski K (2006), pp. 58 – 61; Tomasevski K (2001).

Convention oblige States Parties to pay particular attention to the circumstances of women in rural areas and to women whose education has been disrupted when fulfilling their obligations to eliminate discrimination and promote education and training.[219] All necessary steps should be taken to protect women's and girls' right to education by implementing violence prevention programmes in schools, mitigating the disruptive effects of illness and /or caring responsibilities of women and girls living with or affected by HIV and AIDS, and increasing the availability of training programmes for older women whose education has been disrupted.

Denial of women's sexual and reproductive rights

> *"Everyone has the right to bodily and psychological integrity."* (The Constitution of the Republic of South Africa, Section 12(2)

> *"He did not allow it* [use of condoms]. *I did try. At the clinic I got them and took them home, but he said no. We quarrelled. He did hit me. He overpowered me. …I told the clinic that my husband beat me…The clinic did not tell me what to do….He was forcing me to sleep with him…He was raping me and infecting me."* (JA, a 48-year-old woman living with HIV in rural Mpumalanga)[220]

The South African and other governments participating in the Beijing Declaration and Platform for Action recognized and reaffirmed that the "human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality and reproductive health, free of coercion, discrimination and violence".[221] However AI's delegates found that the sexual and reproductive rights of many of the women whom they interviewed were not being protected and fulfilled, placing them at risk of HIV infection or re-infection. The women's low social status, compounded by economic inequalities, and fear of violence had direct consequences for their ability to discuss with their partners the use of male condoms. Condoms are widely accepted as an effective method for preventing HIV infection and most STIs when used consistently and correctly.[222] According to the NSP, some 350 million condoms annually were being distributed including via the public health sector, social marketing programmes and commercial sales. However the NSP acknowledges that "[p]ower and control disparities in relationships create a context for men to have multiple concurrent partners and fuel their reluctance to use condoms".[223]

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[219] Article 12(2) and Article 14(2)(d) respectively. Hirsch A (2005), p.253 recommends more attention and support for Adult Basic Education and Training (ABET) as a strategy for improving "sustainable livelihoods" within the "second economy". STATSSA Community Survey (2007) shows that in 2001 0.2% of the population below 25 years were attending an ABET program and for 2007 the figure was 0% (p.26, Table 4.2). No information is provided on attendance figures for people over 24 years.

[220] Interviewed on 5 May 2007 with assistance of an interpreter.

[221] Beijing Declaration and Platform for Action (1995), Section C. Women and Health. Paragraph 96.

[222] Shapiro K and Ray S (2007), who refer to research showing that male latex condoms are 80-95% effective in preventing HIV and most STIs, as well as reducing transmission of human papillomavirus and therefore of cervical cancer, when used consistently and correctly (pp.75-76). See also UNAIDS, WHO, UNFPA (2004) and NSP (2007), p.41.

[223] NSP (2007), p.32. It notes that "male condom accessibility, judged according to the quantity of condoms procured and distributed, has significantly improved during the NSP 2000-2005. Condoms are being distributed increasingly via non-traditional outlets, but the number of condoms handed out at these venues remains low compared to overall distribution" (p.46). Shisana et al (2005) referred to "the successful implementation of condom use as an HIV prevention strategy", with public sector clinics and hospitals and pharmacies being the most important sources…[and] that "perceived ease of access [had] also improved in rural formal and rural informal locality types…". (p.71).

TZ, a 50-year-old woman living with HIV, commented to AI that people in her village say that "*those who get HIV/AIDS are prostitutes…* [and that] *if you use condoms you are a prostitute."* She was explaining why she had not disclosed her status to her children.[224] She had also heard worrying stories in her support group, in particular of one woman whose husband would not use a condom and that he would beat her when she said she would not sleep with him as a consequence of this refusal. RH, a 43-year-old mother of five children, said she hears people say in her community that *"you have HIV because you are a prostitute"*. This kind of talk "*hurts me, because I think I got it from my husband"*.[225] She did not know about condoms, she said, when she was living with her husband.

AI was told by NO, a young woman living with HIV, who was also involved in prevention counselling at her local clinic and participated in a support group, that "*women are afraid. They will allow* [their husbands] *to sleep with them without condoms* [because] *they are afraid that their husbands won't maintain them or stay with them."*[226] Thirty-seven-year-old SB, whose husband had died in 2006 as a result of AIDS-related illness, told AI that she believed her "sickness" came from him, and that his first wife had died ten years earlier from this illness. He had tested only shortly before his own death. During their marriage, SB said, he would not agree to them using condoms whenever she tried to raise the issue.[227] ZT, the mother of three young children, told AI that when she tried to ask the father of her two youngest children to use condoms, he would not agree to this and "overpowered" her. He would also accuse her of "running around" when he was not staying with her. He shouted similar accusations at her, including accusing her of being a prostitute, when she told him during her pregnancy with her second child that she had tested positive.[228]

EZ, who was 39 years old and living with her three children and two grandchildren and used to work on orange farms before she became too ill, told AI that her husband had taken a second wife and was staying with her elsewhere in Mpumalanga. When they were living together she had not been able to get him to use condoms. "*He was strict. It was not easy to talk to him. 'Culture, culture' he would say. He liked to have many affairs* [and] *admitted this"*.[229] SE had had similar problems in talking to her husband, who was a truck driver and on the road most of the time. On his days off he would visit her but he refused to use condoms when she asked him. After he abandoned his family she became sick and at the local clinic she tested for HIV and found she was infected. She did not have any knowledge of her husband's health since he left the family.[230]

Among the women interviewed who provided information on this issue, two-fifths of them said that they had never used condoms nor discussed using them with their husband/partner. Nearly a third told AI that they had difficulties in raising the issue of condom use with their partners or that the men would not allow their use or stopped using them because they did not

[224] Interviewed on 4 May 2007 with the assistance of an interpreter.
[225] Interviewed on 4 May 2007 with the assistance of an interpreter.
[226] Interviewed on 5 May 2007 with the assistance of an interpreter.
[227] Interviewed on 4 May 2007 with the assistance of an interpreter.
[228] Interviewed on 4 May 2007 with the assistance of an interpreter.
[229] Interviewed on 5 May 2007 with the assistance of an interpreter.
[230] Interviewed on 7 May 2007 with the assistance of an interpreter.

like them. Three women described being "overpowered", or beaten, and forced to have sex with their husbands who actively refused to use condoms. A different but also worrying perspective was provided by IM, a 49-year-old woman living with HIV, who told AI that she had heard about them, but, *"because I am married, I didn't worry about condoms, because I was staying with my husband."* [231] A migrant worker, he visited their home at the end of every month. When she told her husband about the results of her HIV test, he appeared to accept responsibility, she said, *"because he was staying with another woman* [where he worked, so] *he did think it was because of him"* that she had tested positive. After discussing the situation together, she accompanied her husband when he tested for HIV and found out that he was also infected.

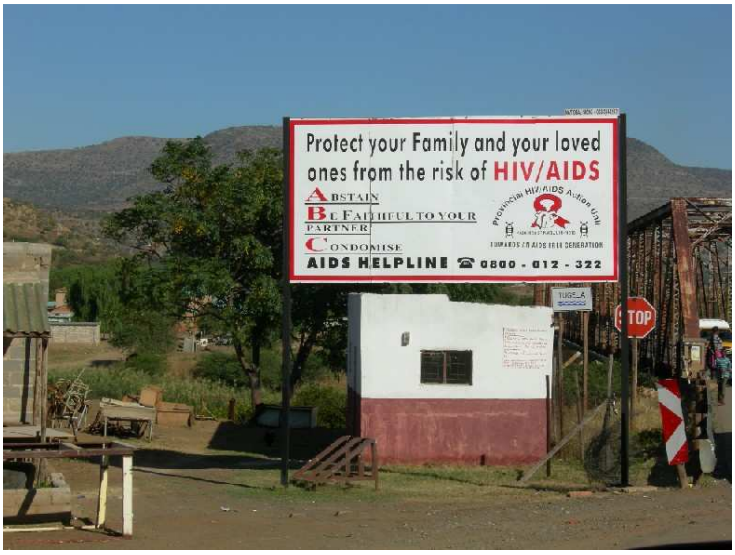
A fifth of the women who discussed this issue, however, did report having supportive partners who agreed to use condoms. Thirty-two-year-old NO said that she had used them before she was tested for HIV. She had in fact known about them from her school days, when a health worker came to her school to explain about using them to prevent transmission of STIs. In her own preventive education work at her local clinic and in schools, she talks about HIV and AIDS, STIs and the use of condoms and is open about her own status. Although, she said, she advises young people to delay sexual activity, she felt that they would not, but at least she hoped they would use condoms. Some of them would come to her for private advice and access to condoms.[232]

The NSP for 2007-2011 concluded from the assessment of the impact of the previous NSP that "behaviour [had] not changed proportionately to levels of awareness [of HIV and AIDS] and availability of prevention methods such as condoms". Accordingly, it would be necessary to review "the approach and content of the Abstain, Be Faithful, Condomise (ABC) strategy" and place "greater emphasis on strategies that are designed to influence behaviour".[233] This recognition is not, however, linked in explicitly with other NSP recommendations intended to improve HIV prevention, such as promoting the education of both men and women "on human rights in general and women's rights in particular", addressing the needs of women in abusive relationships, and addressing the unacceptability of coercive sex, gender stereotypes, the stigmatization of rape survivors and other forms of gender-based violence.[234]

As the stories above illustrate, some women are still experiencing great difficulty in being able to achieve their constitutional right to "bodily and psychological integrity" and human dignity. Their sexual and reproductive rights were not being respected primarily because of the inequality of power in gender relations and social expectations affecting their intimate lives.[235] The resulting denial of autonomy and sense of powerlessness were compounded by the women's precarious economic circumstances, their burden of child care responsibilities and the lack of alternative, safe and adequate housing. In circumstances where they lack the

[231] Interviewed on 7 May 2007 with the assistance of an interpreter.
[232] Interviewed on 5 May 2007 with the assistance of an interpreter. Campbell C (2003) describes the evidence from interviews conducted in Summertown of the effect of peer pressure on young people to engage in sex and for the prejudiced attitudes shown towards young women who carry condoms and ask for them to be used. (pp.121-131).
[233] NSP (2007), p.51.
[234] NSP (2007), pp.10,15, 62.
[235] See also comments and findings of Fox AM et al (2007), p.589; UNAIDS (2004); Vetten L, Bhana K (2001); and Meyer-Weitz A et al (1998). Similar findings are reported in a Zambian-based study published by Human Rights Watch (2007), p.19.

support they need, men's threatened or actual use of violence was another critical factor causing the women to give in to the pressure from their partners for unprotected sex and thereby placing themselves at risk of HIV transmission or re-infection.



A billboard giving the 'ABC' message in rural KwaZulu Natal and promoting the use of condoms as an HIV prevention method. © AI 2007

There is need for strong political leadership to ensure that women's sexual and reproductive rights are respected, protected and fulfilled, as required under the Constitution and human rights treaties to which South Africa is Party. The Minister of Health, in a statement issued in October 2007, stressed that "[c]ondoms are a crucial element of the Department of Health's programme to prevent STIs, including HIV, and unwanted pregnancies [and] through the Khomanani Campaign, … will be making efforts to emphasise the messages that correct and consistent use of condoms is important in preventing …HIV." [236]

In view of the experiences of the women whom AI interviewed and the findings of other research, advocacy and service-providing NGOs, it is necessary and urgent that government prevention programmes and messages carry a clear statement on women's legally protected "right to self protection and to be protected against sexually transmitted infections, including HIV/AIDS", as guaranteed under Article 14 of the Protocol to the African Charter on the Rights of Women in Africa and Sections 12(2) and 27(1) of the Constitution. The Beijing Declaration and Platform of Action also affirmed the obligation to respect, protect and fulfil women's sexual and reproductive health rights as essential for women's ability to achieve the highest attainable standard of physical and mental health.[237]

On the grounds of non-discrimination and equality before the law, these obligations to respect, protect and fulfil women's sexual and reproductive health rights are applicable

[236] Dr Manto Tshabalala-Msimang, 'Condom distribution programme', 22 October 2007. Available at http://www.doh.gov.za/docs/pr/2007/pr1022.html
[237] Beijing Declaration and Platform for Action (1995), Section C. Women and Health. paragraphs 89 to 105 . See Gruskin S et al (2007) for discussion of health systems best practice within a human rights framework.

irrespective of the person's HIV status.[238] The UN Committee on the Elimination of All Forms of Discrimination against Women (CEDAW) has noted that the "obligation to protect rights relating to women's health requires States parties, their agents and officials to take action to prevent and impose sanctions for violations of rights by private persons and organizations."[239] Accordingly members of the government and leading politicians should clearly articulate this aspect of women's rights and condemn abuses, including violence, against women who attempt to assert their sexual and reproductive health rights. The government should ensure that all women have access to an effective remedy, including through the criminal justice system, in response to such abuses.

The 1994 Cairo Program of Action emphasised that equality, education and empowerment of women are central to women's ability to enjoy sexual and reproductive health rights.[240] South African researchers have found a direct correlation between a woman's ability to discuss condom use with her male partner and empowerment.[241] There have also been encouraging results from the use of the "gender-transformative HIV prevention programme", Stepping Stones, in rural Eastern Cape Province. The evaluation of the impact of this intervention indicated that it helped increase men's willingness to accept condom use, improve their communication skills in relationships and accept that violence against women was wrong. There was an associated reduction in STIs among women participants.[242] As part of the implementation of the new NSP, information on women's sexual and reproductive health rights should be included in government-supported public education programmes, including at the community level, to inform women about their rights, help increase men's willingness to accept condom use, and in training programmes for health care providers, VCT counsellors, social workers and others involved in service delivery.

Gender-based discrimination & access to treatment for women living with HIV

> *"States Parties shall 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…"* (Women's Convention, Article 12(1))

[238] Gruskin S et al (2007), p.5; International Guidelines on HIV/AIDS and Human Rights (2006), pp.83-84. See Gruskin S et al (2007), pp.6, 17; Segurado A C, Paiva V (2007), pp. 27-45; Shapiro K, Ray S (2007), pp. 79-85; Policy Project (2006), ICW (2006), section 5, for concerns regarding stigma and discrimination experienced by people living with HIV from health care providers, and raised with AI in a meeting with ICW, Durban, May 2007. See also NMF and MSF (2006), p.13, for the testimony of one young HIV-infected woman who was pressured to undergo sterilisation and the Cape Town-based study by Cooper D et al (2007) for the impact on HIV positive individuals' reproductive choices.

[239] CEDAW, General Recommendation 24: Women and health, at para.15.

[240] Programme of Action of the International Conference on Population and Development, Principle 4 and Chapter 4, in Report of the International Conference on Population and Development (Cairo, 5-13 September 1994), UN Doc.A/CONF.171/13 (18 October 1994). Copelon R (1995).

[241] Jewkes RK et al (2003). AI interview with PWN, Johannesburg, 29 October 2006; AI interview with POWA, Johannesburg, 30 October 2006.

[242] SikweyiyaY et al (2007a), p.50; Jewkes R et al (2007). Stepping Stones is a Ugandan-developed life-skills and community intervention program, Information provided to AI during meetings with Stepping Stones researchers, University of the Witwatersrand, 28 October 2006 and Medical Research Council, 14 May 2007. See also Barker G et al (2007) on the evaluation of the impact of 58 similar programs globally. On the original Stepping Stones program developed for Uganda see Welbourn A (1995). PACSA (2007) provides an example of a faith-based awareness raising program on women's sexual and reproductive rights in the context of the HIV epidemic.

TH's story[243]

"TH", a 35-year-old mother of four children living with her husband's family in a rural homestead and without access to any independent economic resources, told AI of her distress at the domestic conflict which had developed during the illness and then death of her husband's second wife. TH's husband worked away in Gauteng and she took on the burden of caring for his second wife during her long illness. She was the only one regularly visiting her, TH said, as the sick woman was hiding her condition from most people and had shared with a few others but not her husband that she had HIV.

TH eventually approached a support centre in another area for assistance and training in caring for people ill with AIDS, as well as receiving some counselling for herself. During one of these visits to the centre, the second wife died. Now her husband, his family and others in the community were blaming her for abandoning the sick woman and being responsible for her death. She was accused of having "no shame" and it was implied that her "running around" had brought the virus into the family. During the second wife's illness, TH had tried to raise with her husband the issue of protection from HIV transmission. But he would say to her, "you think you are very clever" and would be angry with her.

After TH herself tested positive she disclosed her HIV status to her husband, who was angry and abusive towards her for having gone for an HIV test without his permission. He took away the medication (immune boosters) she had been given when she tested positive, commenting "I am the one who goes to the chemist, not you." He told T, "You talk so much, with your big mouth, with this sickness of yours; you must live with it."

South Africa has obligations under international human rights law and its Constitution to protect and promote women's right to the highest attainable standard of health without discrimination.[244] The Constitution prohibits discrimination on the grounds of gender or sex, and protects the "full and equal enjoyment of all rights and freedoms", including the right to have access to health care services.[245] Section 27(2) also obliges the state to "take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation" of this right. As an important step towards fulfilling this obligation, the National Health Act (61 of 2003), which was intended to provide a constitutionally compliant framework for a structured uniform health system, has, as one of its objectives, "protecting, respecting, promoting and fulfilling the rights of…vulnerable groups such as women".[246] AI's research provides some evidence, however, that gender-based discrimination, including in the social sphere, and violence against women, which is itself a form of gender-based discrimination, are undermining rural women's ability to have access to information, health care and treatment. HIV-related stigma is also acting as a barrier to their access to health services and their ability to adhere to treatment. The International Guidelines on HIV/AIDS and Human Rights has drawn the attention of governments to the need to address"[s]*ystematic discrimination based on gender* [which]…*impairs women's ability to*

[243] Interviewed on 7 May 2007 with the assistance of an interpreter.
[244] The African Charter, Article 16; Protocol to the African Charter on the Rights of Women in Africa, Articles 2 and 14; the Women's Convention, Articles 11.1(f) and 12; the ICESCR, to which South Africa is a signatory and thereby should refrain from actions that would defeat the treaty's object and purpose, including under Article 12(1) which recognizes "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health."
[245] Sections 9 and 27(1) (a).
[246] Chapter 1, Section 2(c) (iv) of Act No.61 of 2003: National Health Act (which was signed into law on 23 July 2004).

deal with the consequences of their own infection…in social, economic and personal terms".[247]

As TH's case highlights, women may face abuse from their partners when attempting to have access to health services for HIV-related treatment and care. Where the woman's partner is in denial about his own HIV status he may resent her going to the clinic, or taking medication. AI interviewed a number of other women who had also experienced abuse by their partners when they tried to have access to health services, or had been actively prevented by their partner from having access to these services and the medication they required. Sometimes it was the woman's fear of the possible reaction by her partner or members of the wider family that had an impact on her health seeking behaviour. The potential for abuse or the extent of the woman's fear of abuse was exacerbated by her low social status, the stigma surrounding the illness and limited access to independent economic resources, as evident in TH's story.

Some of the women interviewed by AI described how they hide the medication in their homes, as they feared their HIV status may be revealed to members of the household. Thirty-two-year-old SP, who lived with her mother, her 17-year-old daughter and new born grandchild, told AI that she had not told her mother about her HIV-infected status. She would hear her mother say in response to something she had seen on television that *"she did not want to see her daughter with this sickness and if she did get sick she would not give her support"*. SP, who was not on ARVs but was taking immune boosters, said that sometimes her mother would ask her why does she take those pills? *"I tell her that they are for headaches… [and] I hide them"*.[248]

Women living with HIV and faced with the consequences of stigma may also be more likely to stay with an abusive or violent partner. RE[249], aged 45, told AI: *"I discovered I was HIV-positive in 1997."* She told AI about her current partner and father of her youngest child. He knows she is living with HIV, but is sometimes abusive.

> *"If I have a fight with* [him], *then if I decide to leave him, it will not be easy for me to find another boyfriend because I will have to start to explain all my status and all. Right now I have someone who knows what is happening…So I'd better stay with him. He does not have a good job, but I can't leave him because it will be difficult for me."*

When talking about beatings at the hands of her husband who had died in 2002 from AIDS-related illness, she commented that when she visited her local clinic the nurses had not provided her with advice about shelters. Very few of the women whom AI interviewed who had gone to a clinic seeking medical care for injuries or advice about domestic violence had been referred on to support services or a shelter by the clinic.[250]

Violence, other abusive conduct or prejudice were not manifested only by a male partner. As indicated in the stories above, it was sometimes the husband's family, or a woman's own

[247] UNAIDS and Office of the UN High Commissioner for Human Rights (2006), p.85, paragraph 110.
[248] Interviewed on 4 May 2007 with the assistance of an interpreter.
[249] Interviewed on 7 May 2007 with the assistance of an interpreter.
[250] See above chapter 2 regarding this gap in services.

family, or neighbours or others in the community who were being abusive towards her and in ways which had an impact on her ability to make the best decisions for her health and well-being.

PK's story[251]

PK, a 34-year-old mother of four young children under seven years, including twin boys, had been widowed since 2005 when her husband died from AIDS-related illness. She had tested positive while pregnant with her last child and received PMTCT. Her husband was critically ill at the time; he tested positive shortly before he died. Her husband, she said, had been "very supportive" and had worked as a security guard before he became ill.

After her husband's death, she and her children went to stay with her family. However she experienced conflict with them as a result of her status, which she had disclosed to them. *"They were abusing me about my status. They used to call me names and just say whatever they wanted to say and say it because of the HIV/AIDS."* Consequently she felt she had to leave her family home.

PK, who had been taking ART since 2006, needed to collect her medication once a month from hospital. She managed to cope with the transport costs, of R30 (US$4) return, only because she was receiving government child support grants for her young children and the short-term disability grant for people who are living with HIV and AIDS and are too ill to work.[252] The hospital tried to assist her apparently by providing her with some additional tablets to minimise the likelihood that she would run out of tablets before she had the money to visit the hospital again. She told AI that she managed somehow not to miss her twice daily dose. While there was no support group at her hospital, she was able to share her problems and get support in taking ART with two women friends who were also HIV-infected.

In view of these personal, social and economic pressures and the obstacles to self-protection, treatment and care experienced by the women whom AI interviewed, an effective state response to HIV and AIDS would need to include building into health services improved capacity for social support, intervention and referral. As noted by the UN Committee on Economic, Social and Cultural Rights (CESCR), "[t]he realization of women's right to health requires the removal of all barriers interfering with access to health services…" [253] The women's testimonies suggest that their ability to have access to HIV-related treatment and care and to adhere to treatment is influenced by their experience or fear of violence, abuse or discrimination from an intimate partner, family members or the wider community. Limited access to economic resources constituted another barrier to access to health services. These circumstances indicate a high level of need in clinic and hospital-based services to take account of these barriers and to ensure that services are adequate and appropriate in responding to the needs of women patients experiencing threats or actual violence and other consequences of stigma and discrimination.

As recommended in the International Guidelines on HIV/AIDS and Human Rights, a human rights-based response should include developing greater awareness of and capacity for screening by health service staff and VCT counsellors for the risk of violence and other manifestations of inequality and discrimination faced by women living with HIV, and

[251] Interviewed on 7 May 2007 with the assistance of an interpreter.
[252] See Chapter 5 below for discussion on these social support grants.
[253] CESCR, General Comment No.14 (2000), paragraph 21.

establishing systems for support, referral and follow-up. Additional and periodic training may be necessary for health care staff and VCT counsellors.[254] Close working relationships between health care staff and home-based care and NGO-service providing organizations will increase the accessibility and relevance of health services for women living with HIV and, in turn, may help create greater awareness and support within the community for them.[255]

AI delegates visited one rural hospital in KwaZulu Natal which provided an example of good practice in this regard. Its ART programme incorporates community-based support and follow-up through a network of volunteers. The volunteers include lay-counsellors, who have been trained as treatment adherence monitors, and home-based care assistants, working in a catchment area of very scattered homesteads over 1700 square kilometres. They worked together also with Community Health Workers who are paid by the provincial DoH. Where home visits revealed that women were at risk of violence or being forced to leave their homes because of their status, which would also jeopardise their ability to adhere to treatment, the members of these various support structures would try to assist women, or in cases of severe abuse or violence make referrals to officials from the department of social welfare or intervene with police services.[256]

The NSP observed that there had been a growth in community and home-based care schemes, some of which involved financial remuneration for the carers. The NSP includes the provision of psychosocial support and implementation of community-based treatment adherence programmes as part of the "scale up" of a "comprehensive care and treatment package" over the five-year period.[257] The successful implementation of these measures could contribute significantly to the realization of the right to health of women living with HIV and AIDS.

It is vital also that the state intensifies efforts to address women's wider social and economic inequalities which act as barriers to effective prevention, treatment and care for HIV and AIDS. An increased monitoring and mobilising role by a strengthened Commission for Gender Equality, in conjunction with the parliamentary Joint Monitoring Committee on Improvement of Quality of Life and Status of Women and other parts of the "gender machinery" could assist in identifying gender gaps and pressurising departments of state to deliver sustained and effective interventions.[258] At the conclusion in 2003 of a large-scale study into the relationship between gender-based violence and HIV, the researchers

[254] The weaknesses in the training provided to and the limited capacity of those involved in providing VCT services in clinics and hospitals were highlighted to AI by a number of organizations in interviews in October 2006 and May 2007, including TLAC, Masisukumeni Women's Crisis Centre, the Medical Research Council and the Centre for the Study of AIDS and the AIDS & Human Rights Unit of the Center for Human Rights, University of Pretoria.

[255] International Guidelines on HIV/AIDS and Human Rights, Commentary on Guideline 6, at para. 26

[256] Information received during a meeting with staff at Church of Scotland Hospital, Tugela Ferry, 8 May 2007. Other examples included the MSF projects in Lusikisiki in the Eastern Cape and Khayelitsha and projects sponsored by ARK (see chapter 5).

[257] NSP (2007), pp.48,85,86.

[258] See the analysis of the failures of the Gender Commission of Inquiry by and the recommendations of The Asmal Committee (2007), pp. 147-164 and similar concerns raised in the hearings held by the Justice and Constitutional Development Portfolio Committee in November 2007 (Available at: http://www.pmg.org.za/viewminute.php?id=9709). Also in November 2007 the Joint Monitoring Committee on Improvement of Quality of Life and Status of Women held hearings critical of the continuing lack of systematic attention to "gender budgeting" in government departments and on the functioning of the Office on the Status of Women (accessed at: http://www.pmg.org.za/viewminute.php?id=9692).

recommended that priority should be given to training for health care staff "on gender, screening for gender-based violence, listening and supporting women", in order to give them the capacity and ability "to identify women who have experienced intimate partner violence and provide an appropriate and helpful response". The researchers appealed as well for an increased focus in HIV prevention programmes on targeting "male sexual risk taking, condom refusal and violent behaviour" and working towards "transformation of broader social structures which support female subordination and hinder women's socio-economic empowerment".[259] These calls remain as urgent now as before.

[259] Dunkle K et al (2003), pp. 52-53.

4. HIV testing and disclosure of results

"He left me because I was HIV-positive. He reacted badly…[and] said that he does not have it. He used vulgar words against me." [PY, a 28-year-old woman who tested positive and informed her partner in 2006]

"States should, in collaboration with and through the community, promote a supportive and enabling environment for women." [International Guidelines on HIV/AIDS and Human Rights][260]

Testing for HIV is an important element in an effective state response to HIV and AIDS. It is "never a goal in itself, but clearly linked to larger prevention and care, treatment and support goals."[261] Enabling people to know their HIV status means they can access treatment, care and support if positive, or take further steps to protect themselves against infection if negative. It also means those living with HIV can protect sexual partners from HIV infection, and themselves from re-infection with another strain of the virus. For pregnant women there is an additional benefit from testing for HIV. Where there is a prevention of mother-to-child transmission (PMTCT) programme available, a woman with access to such treatment can dramatically decrease the chances of passing HIV to her baby.

A major objective of the new NSP is "to create a social environment that encourages many more people to test voluntarily for HIV and, when necessary, to seek and receive medical treatment and social support". [262] It adds that "[r]espect for and the promotion of human rights must be integral to all the priority interventions of the NSP". This is important as testing, in addition to its manifest benefits, can also provide an opportunity for abuses of human rights. Not only can the circumstances of the test itself represent a violation of a person's rights – for example, through denying a person the opportunity to freely choose to test or disclosing the results of the test to third parties without the consent of the person affected – but also through forms of post-test discrimination, such as denial of services, and acts of violence perpetrated on the basis of a person's HIV status.

The interviews conducted by AI suggest that there remain major obstacles to achieving the NSP goal on testing. These include an environment of gender-based inequalities in which women can experience harassment or violence (or fear violence) when they test positive and wish to disclose their status to a male partner; or abandonment (or fear of abandonment); or lack of access to services which should flow from a positive test; or the refusal or reluctance by male partners to undergo an HIV test after the women have tested positive or have expressed a wish for both of them to be tested.

[260] International Guidelines on HIV/AIDS and Human Rights (2006), Guideline 8.
[261] Jurgens R (2007).
[262] NSP (2007), pp 59-63.

Human rights standards

Testing strategies must therefore require careful balancing of health-related goals and protection of the rights of those being tested.[263] The "voluntary counselling and testing" (VCT) model, based on information and consent, has been long advocated as the best way of striking this balance. However, in order to overcome the lack of take up of existing testing possibilities as well as to more energetically scale up testing, there has been a move globally towards testing undertaken by providers of antiretroviral medication – so-called provider-initiated testing and counselling (PITC). PITC can be based on an offer of testing accompanied by counselling with individuals consenting to testing should they wish to do so (as with VCT). However PITC is increasingly being equated with an "opt-out" model of testing in which a person attending a clinic would be tested as a matter of course unless he or she expressed a wish not to be tested (i.e. they would "opt-out"). The WHO and UNAIDS have now issued guidelines for PITC.[264]

In their guidance for provider-initiated testing and counselling, WHO and UNAIDS suggest that at least the following prerequisites should be assured:

- Access to HIV prevention, care and support services, including a "reasonable expectation that it will become available within the framework of a national plan to achieve universal access to antiretroviral therapy for all who need it".[265]
- "Where there are high levels of stigma and discrimination and/or low capacity of health care providers to implement provider-initiated HIV testing and counselling under the conditions of informed consent, confidentiality and counselling, [that] adequate resources must be devoted to addressing these issues prior to implementation."[266]

Pregnant women can benefit from testing in order to address their own future health and that of their growing foetus. However, testing should be carried out with particular attention to the woman's right to counselling and confidentiality. Possible partner violence following disclosure emphasises the need for respect for confidentiality in ante-natal testing. Moreover, considerable effort should be made to ensure that women have access to voluntary counselling and testing before the point of labour and delivery to ensure that they can make an informed and considered decision rather than one made during a period of stress and possible pressure from health professionals. Earlier, rather than later, testing is also likely to reduce the additional stress experienced by the woman learning her status during labour and delivery.[267]

Social barriers to testing

UNAIDS estimates that worldwide only 12 per cent of people living with HIV have access to a test, a situation which highlights the urgent need to strengthen access to testing,[268] as access for an HIV-infected person to treatment, care and support requires confirmation of their HIV

[263] Jurgens R (2007).
[264] WHO (2007).
[265] WHO (2007), p.30.
[266] WHO (2007). p.45.
[267] Gruskin S et al (2007), p.8; Segurado A C, Paiva V (2007), pp.29-30.
[268] UNAIDS (2007a).

status. However, the right to an HIV antibody test has implications beyond the ability of a person to access a test. It is also about a person's perception of HIV and the care, support and treatment likely to be available once tested. Where people think that the benefits of knowing their HIV status outweigh the risks, and where levels of stigma and discrimination are low, people are more likely to test for HIV.[269] The benefits to people knowing their HIV status are closely related to their ability to access treatment in case of a positive test result. In addition, according to a WHO review,[270] fear of negative social outcomes was a related consideration and a major reported barrier to disclosing HIV status. In turn, an inability to disclose could have a negative impact on the person's ability to adhere to treatment or cope with its side-effects. While, according to the WHO, most individuals who chose to disclose their status reported experiencing positive social outcomes, including support and understanding from partners, others reported experiencing blame, abandonment, anger, violence, stigma, and depression. In studies that looked at violence as a possible outcome of HIV status disclosure by women who chose to disclose, violent outcomes were reported more often by women in sub-Saharan Africa. The most common reasons given in a review of barriers to disclosure were "fear of abandonment, fear of rejection/discrimination, fear of violence, fear of upsetting family members and fear of accusations of infidelity."[271] This leads many women not to disclose to their partners. In one study, 50 per cent of the rural South African women involved in the study had not disclosed their status to anyone including their partner.[272]

Abuses and abandonment of HIV-infected women by their partners

While there are many good reasons to test, and sound medical grounds for scaling up testing, as indicated above the question is more complex in a context of gender inequality, poverty and violence. Where women are tested in greater numbers than men and with limited support, it can leave them vulnerable to stigma, discrimination, abandonment and violence.[273] Limited studies have shown that women disclosing their HIV status to male partners are at risk of negative outcomes though it is usually not clear in existing studies how the violence post-disclosure compares to the level of violence before disclosure.[274]

The women AI interviewed spoke of their own experiences of powerlessness, threats of violence, verbal and physical abuse and abandonment in response to disclosing their HIV status. One young woman, PY, told AI that she had been abandoned when she informed her partner in 2006 that she was HIV-infected. The 28-year-old, who lived with her auntie and uncle and small daughter, said that she was separated from her child's father. "*He left me because I was HIV-positive. He reacted badly*…[and] *said that he does not have it. He used vulgar words against me*." [275] He now lived in another province, where he was working. She added that, before she had told him her status, he did maintain her and the child, but not now. She had not been able to find any work and her aunt and uncle could not maintain her and her

[269] Kalichman SC, Simbayi LC (2003).
[270] WHO (2004b). See also: Medley A et al (2004).
[271] WHO (2004b), p.11.
[272] Matthews C et al (1999). AI interview with WISER, University of the Witwatersrand, Johannesburg, 31 October 2006.
[273] UNAIDS (2003).
[274] WHO (2004b).
[275] Interviewed on 5 May 2007 with the assistance of an interpreter.

daughter. In part this was because they were responsible for three children of their own, all of whom were living with HIV and AIDS.

A young woman, ML[276], was living with her parents, siblings and HIV-infected two-year-old daughter when AI interviewed her. She said that she was too afraid to tell the father of her child the result after she tested positive in 2004. She was pregnant at the time and was sick and vomiting blood. Their relationship was also ending. She had gone to her boyfriend's place after she had learnt her results, but on learning that he had another girlfriend, she *"feared he would be angry"* if she told him she was positive. She recalled that her "*boyfriend used to be sick. I had been told that he had TB; he took traditional medicine* [but] *he would not listen to me tell him he should go to hospital."*

AI heard similar evidence from 30-year-old SK,[277] who tested in late 2006 and had separated from the father of her 18-month-old child. For two months she had delayed telling him her status, sharing the news only with her aunt. She told AI that

> "*I started to tell him after I started to be on ARVs….* [But] *he just said it is better to separate. So I asked him, what if you can go and test and you find out you are positive. And he said, no. He said he does not have a problem, but* [we] *have to separate*."

He was now living in another town. However, she said, he did continue to contribute to the support of their child, although she still had to struggle to support this child and an older child, as well as five younger siblings following the deaths of their parents. Every three months she had to travel to the hospital to collect her ARVs and her aunt borrowed the money to ensure she could do this.

Other women said they did not inform their male partner for fear of facing abandonment. SB, the mother of a seven-year-old boy and a widow,[278]told AI that when she became ill and sought help at the local clinic, she was advised to test for HIV. At that time her husband was far away working in another province. She travelled to where he was working and told him that she was thinking of going to do a test. He said to her that if she is thinking of doing a test, then she should not come back to him.

> *"I asked him why and he told me that if you can go and test and find out that you are positive, you know where you took that virus from, it's not from me".*

She became upset describing what in fact happened to her husband, who became ill in late 2006 and died within three months. Shortly before he died he tested at the local clinic, but never disclosed the result to her. SB believed that he had become infected from his first wife who had died nearly ten years earlier.

[276] Interviewed on 5 May 2007 with the assistance of an interpreter.
[277] Interviewed on 5 May 2007 with the assistance of an interpreter.
[278] Interviewed on 4 May 2007 with the assistance of an interpreter.

Men's reluctance to test

A few of the women whom AI interviewed said that that their partners had agreed to test in response to the news of their test results. Among them was IM, a mother of five children who had tested in 2003.[279] When she informed her husband, he seemed to accept that she may have become HIV-infected because he was having another relationship in the area where he worked. He agreed to test and found that he was positive as well. However the great majority of the women interviewed told AI that their male partners were reluctant to test for HIV, or had refused to test, even where there appeared to be strong indications that the men were HIV-infected. This typical response has important implications both for the health of the women and for wider public health concerns, not even taking into account the possibility of the men themselves benefiting from testing.

Forty-five-year-old RE,[280] from KwaZulu Natal, who had known her HIV-infected status for nearly ten years, had been with her current partner for three years. He knew her status, she told AI, and was supportive of her and their young child who was born in 2006. When asked if she knew if he also was HIV-infected, she described his attitude as a mixture of knowing but not wanting to know.

> "*He does not want to go to test…He knows he is positive. He is also taking pills from a doctor. But the thing is, he does not want to go to check*."

KE's late husband had shown similar reluctance to test. She had gone to the local clinic feeling ill with stomach problems and diarrhoea, and, after taking a test, learnt that she was HIV positive. She told AI that she in fact had asked her husband before this occasion to take an HIV test together with her, as he was sick and complaining of sores and herpes. He had declined to go with her. When she told him about her test results,

> "*he did nothing. He did not show any reaction, bad or otherwise. He just said he would go another day*."

He never tested before he became critically ill. On the day before he died KE gave her consent to the medical staff for him to be tested, so that she could be informed of his status for her own peace of mind.[281]

Some women felt that their partners had deliberately withheld information about their status, among them JA, who told AI that

> "[my] *husband died five years ago… He was sick, he had HIV but had kept it a secret from me. I found out after his death. Then I tested while I was still wearing mourning [clothes]. I was always sick, so I had been advised* [by the local clinic] *to test*."[282]

While her husband was alive she had endured incidents of violence at his hands, in particular when she had asked him to use condoms.

[279] Interviewed on 7 May 2007 with the assistance of an interpreter.
[280] Interviewed on 7 May 2007 in English.
[281] Interviewed on 5 May 2007 with the assistance of an interpreter.
[282] Interviewed on 5 May 2007 with the assistance of an interpreter.

In addition to the testimonies of the women, AI was informed by others, including health care providers, organizations supporting people living with HIV and AIDS and advocacy groups working with men – that men are reluctant to test for HIV. The comparatively low percentage of men receiving ART in South Africa – 30 per cent of the total receiving ART by September 2006 – suggests that considerably fewer men than women know their status or seek access to treatment and care.[283]

While these testimonies represent individual experiences, they do suggest the nature of the immense challenge which many women face when disclosing their HIV-infected status to their partners. They face the prospect of abandonment and abuse from their male partners who typically refuse to be tested and live in denial of their likely infected status. These circumstances highlight the need for increased support services for women when tested for HIV and greater efforts to encourage men to get tested, including with their partners. It appears necessary that in a context of pervasive gender inequalities, stigma and violence women's safety and well-being are at risk and so particular attention should be paid by those

Community health worker, Nothobile Nongqotho, counsels a young HIV-positive woman with her grandmother, during a home visit in a rural area of the Eastern Cape Province. © REUTERS/Mike Hutchings 2005

providing HIV testing services to anticipating and addressing possible adverse consequences for women at the point of disclosure.[284] They should ensure that testing services include

[283] WHO, UNAIDS, UNICEF (2007). AI interview with WISER, 31 October 2006; AI interview with Sonke Gender Justice Network, Cape Town, 10 May 2007.
[284] Dunkle K et al (2003).

screening for risks of gender-based violence or other abuses, and skills and capacity to assist women to cope with the process of disclosure to their male partners, as well as other family members. During post-test counselling women should be provided with information on and means to access support through community outreach programmes and referrals to social welfare agencies, as needed.[285]

During the past four years, with the increased availability of ARV treatment for AIDS, the proper approach to, and importance of, testing has received growing attention in South Africa.[286] Where no treatment for HIV is available, not knowing one's status has limited implications for the ability of the person living with HIV to protect their health.[287] In view of the extent of HIV-related stigma and discrimination in South Africa and elsewhere, the principles of confidentiality, consent and voluntariness featured strongly in international guidelines on HIV testing during the period of limited access to treatment.[288] However, where an HIV test is the precondition for a person being able to have access to increasingly available life-saving medication, the medical rationale for testing is much more compelling. This shift of the context of HIV in South Africa, as in many other countries, has led to a change in the international policy to guide testing procedures. WHO guidelines published on 30 May 2007 recommend that for every patient who visits a clinic in countries that have generalised epidemics, such as South Africa, should be routinely offered an HIV test.[289] This means that the patient still can refuse to be tested, but has to specifically decline it.[290]

In health care facilities visited by AI, testing of pregnant women for PTMTC was available. Staff told AI that all pregnant women test for HIV, but that the test was voluntary and women agreed to the test. However the facilities seen by AI were frequently crowded, with limited possibilities for calm discussion in a confidential setting which might include consideration of the possible negative outcomes of testing. These circumstances present a serious challenge for staff seeking to obtain informed consent, and the views and authority of the health professionals may be key factors in a woman's decision.[291] In a large-scale study carried out

[285] The Office of the Premier of KwaZulu Natal informed AI that they are developing a referral system at provincial and municipal level with a directory of services and a toll free number (AI interview by phone 12 February 2008).
[286] And also globally, as in 2003, the WHO launched a campaign to provide life-saving antiretroviral treatment to 3 million people in developing countries by the end of 2005. This '3 by 5 campaign' represented the first commitment to make this medication accessible to people too poor to purchase it. Governments have since committed themselves at the UN to provide universal access to treatment to all people who require it, by 2010.
[287] There are some psycho-social benefits to a person knowing his or her HIV-infected status, including a greater awareness on healthy living and nutrition which, for example, has been shown to confer significant benefits. However, in the absence of treatment little can be done about the underlying infection. A detailed report by a 15-member consensus panel of the Academy of Science of South Africa (ASSAf) reported in August 2007 that there is no evidence that healthier eating is any substitute for correctly-used medical drugs for HIV/AIDS. See ASSAf (2007).
[288] Office of the United Nations High Commissioner for Human Rights and the Joint United Nations Programme on HIV/AIDS (2006).
[289] WHO, UNAIDS (2007). Generalised epidemics are defined as occurring where there is greater than five per cent prevalence in a population.
[290] This new policy has received a mixed response internationally with some specific concerns being expressed about human rights. These have been discussed in Jürgens R (2007). See also UNAIDS Reference Group on HIV and Human Rights (2007).
[291] Segurado AC, Paiva V (2007) commented that while the "opt-out" approach "is usually associated with wider coverage, there is still concern that it may turn into imposition of HIV tests, since many patients are reluctant to challenge health care procedures." (p.29)

in a country with similar HIV prevalence to South Africa it was found that more than 60 per cent of women reported they felt unable refuse a test when offered.[292]

Testing is being promoted also in a context where the majority of people attending clinics and hospitals are women. Consequently the gender imbalance in people knowing their status is likely to grow and with it the negative consequences for women and men. There are indications that this is already a significant problem, from the fact that comparatively few men are receiving ART, and from the negative consequences after disclosure described by women interviewed by AI. This trend of a relatively high number of women testing compared with men, together with the pattern of women being subjected to various forms of abuse and abandonment, reinforces the need to build into testing programmes a capacity to address systematically the consequences for women of disclosure of HIV status. The International Community of Women living with HIV/AIDS (ICW) issued a policy statement in 2006, in which they specifically voiced their concern about the impact of testing for HIV without greater support for women.[293] A representative of ICW reiterated these concerns to AI in 2007, highlighting the growing risks due to the greater number of women than men testing in South Africa.[294]

In addition to using testing for HIV as an entry point to screening for violence and other abuses against women, ensuring confidentiality and addressing stigma need to be part of programmes to scale up testing. AI's findings also highlight the need for government and other actors, who seek to counter the potentially negative impact of testing on women, to address the underlying causes which make women vulnerable to HIV and violence. The responses should include for instance greater protection for women's right to equality, improvement in their access to economic resources and effective remedies in response to violations of their human rights. Unless these underlying factors are addressed women will remain vulnerable to the threat or reality of gender-based violence, abandonment and denial of access to services and feel constrained not to disclose their status.

AI findings also underline the need to ensure that larger numbers of men actively seek testing for HIV. The South African government has acknowledged this need in the NSP. However, it will require funding responses to HIV and AIDS in South Africa by both the South African government and donors, to increase targeted support for initiatives that ensure men test in greater numbers.

[292] Physicians for Human Rights (2007), pp.43-44; the corresponding figure for men was 76 per cent. The majority of the women had been tested at VCT centres and public hospitals. Only 7 per cent of the women in the sample population were tested in an antenatal setting. See also: Weiser SD et al (2006). AI found in the Caribbean that some people were unaware that they had been tested for HIV due to a lack of comprehensive and appropriate pre-test counselling (Amnesty International (2006)).
[293] ICW (2006).
[294] Interview with ICW, Durban, 9 May 2007. Similar concerns were also raised in a meeting with OSISA, Johannesburg, 30 October 2006, in relation to Southern Africa as well as South Africa.

5. Poverty as a barrier to the realization of rural women's right to health

"I have to go to the clinic once a month [to collect ARVs]. *It is R40 return. I have to borrow the money every way I can."* (Testimony of LK, a woman living with HIV in rural KwaZulu Natal)[295]

"The interpretation of the right to equality is central to women's attainment of all other constitutional rights…. Most significant is the need for an understanding of women's socio-economic conditions to inform the meaning of equality…[A] substantive equality right should lead to the eradication of women's socio-economic disadvantage." [296]

KE's Story[297]

Not long after her husband's death KE had been told at the local clinic that she needed to start antiretroviral therapy (ART) at the nearest hospital urgently, but she was constrained by two major problems. The first was that she had lost her Identity Document (ID), which she believed was a precondition for accessing ART. The National Department of Health had issued an instruction to provincial departments of health confirming that "patients should not be denied ART because they do not have an ID." The local clinic apparently did not inform KE of this fact or had not themselves been so informed by the Mpumalanga Department of Health.[298]

The second barrier for KE to access to treatment was her lack of any financial resources for the cost of a new ID from the Department of Home Affairs (DHA) and the cost of transport to the nearest DHA office and to the hospital itself. KE has no independent income, having stopped seasonal work on a commercial farm some time ago after becoming too ill to work, and was dependent on her aunt, who in turn had to support herself and other family members including seven orphaned children on a pension and a number of child support grants.

KE became upset when describing to AI that *"sometimes there is no food at all"* and she and other members of the family went to sleep without eating.[299] She said that the clinic had been informed about her situation. *"I did explain and they said try and get the money. But I cannot get the money"*. A local NGO was trying to assist her but her health was deteriorating fast.

The UN Committee on Economic, Social and Cultural Rights (CESCR) has commented that:

[295] Interviewed on 7 May 2007 with the assistance of an interpreter.
[296] Bonthuys E and Domingo W (2007), p. 78.
[297] Interviewed on 5 May 2007 with the assistance of an interpreter.
[298] See letter from Dr N D Kalombo, Project Manager: Comprehensive HIV & AIDS Care, Management and Treatment Plan, NDOH to Provincial HAST Managers and Provincial CCMT Project Managers (undated)), in which it is noted that access to treatment should be allowed "if all issues affecting adherence have been addressed and the treatment team is convinced that the patient stands to benefit from the intervention" (accessed at www.alp.org.za/print.php?sid=324). In addition it appears that the providing hospital can generate a unique patient number for testing and follow-up purposes, pending the patient's receipt of a new ID document, as was the practice for instance at Church of Scotland Hospital in KwaZulu Natal province (AI interview with hospital staff, 8 May 2007).
[299] Interviewed by AI 5 May 2007 with the assistance of an interpreter.

> "[H]*ealth facilities, goods and services must be accessible to all, especially the most vulnerable or marginalized sections of the population, in law and in fact, without discrimination on any of the prohibited grounds*."[300]

As a consequence of gender-based discrimination and other factors, women are disproportionately infected and affected by HIV and at the same time carry a disproportionate burden of poverty in South Africa, as in many other countries in sub-Saharan Africa.[301] South Africa has obligations under international human rights law, regional human rights treaties and national law to eliminate discrimination in the realization of the right to health. The African Charter requires that every individual should have the right to enjoy the best attainable state of physical and mental health, without distinction of any kind.[302] South Africa has signed but not ratified the International Covenant on Economic, Social and Cultural Rights (ICESCR) which guarantees the right to the highest attainable standard of physical and mental health. It also prohibits discrimination, including discrimination based on economic status. As a signatory to the ICESCR, South Africa has the obligation to refrain from actions that would defeat the treaty's object and purpose. The South African Constitutional Court has also considered the standards set out in the ICESCR as well as the authoritative interpretation of the Covenant by the CESCR when interpreting the Bill of Rights in the South African Constitution.[303] The African Commission on Human and Peoples' Rights has also used the interpretative work of the CESCR in its interpretation of the African Charter.[304]

The CESCR has set out the framework for the implementation of the highest attainable standard of health in its General Comment 14. It has identified four main elements of the right to health: availability of functioning health care facilities, goods and services; that these health care facilities should be physically and economically accessible to everyone without discrimination; and acceptable ethically and culturally, as well as scientifically and medically appropriate; and of good quality.[305] The Women's Convention obliges South Africa to eliminate discrimination against women in the field of health care.[306] It also requires States to

[300] Paragraph 12(b)(i) (E/C.12/2000/4). The prohibited grounds include "any discrimination…on the grounds of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation and civil, political, social or other status, which has the intention or effect of nullifying or impairing the equal enjoyment or exercise of the right to health." (paragraph 18).

[301] The disproportionate burden of poverty carried by women and the implications of this for the realization of a range of economic and social rights was highlighted by the CESCR in "Poverty and the International Covenant on Economic, Social and Cultural Rights," Statement Adopted by the Committee on Economic, Social and Cultural Rights on 4 May 2001, E/C.12/2001/10, paragraphs 5 and 7. Available at: http://www.unhchr.ch/tbs/doc.nsf/(Symbol)/E.C.12.2001.10.En .

[302] Articles 16 and 2.

[303] This is in line with section 39 of the South African Constitution, which requires all courts to consider international law when interpreting the Bill of Rights. See the ruling of the Constitutional Court on 4 October 2000 in *Government of the Republic of South Africa and Others* v. *Grootboom and Others*, Case CCT 11/00, paragraphs 26-33, 36, 45.

[304] See *Social and Economic Rights Action Centre (SERAC) and The Centre for Economic and Social Rights (CESR) v. Nigeria, (2001), Communication No. 155/96, (African Commission on Human and Peoples' Rights), available at* http://www1.umn.edu/humanrts/africa/comcases/155-96b.html. See also the statement adopted by the African Commission affirming non-discrimination and equal treatment as the key components of economic, social and cultural rights (adopted as the Declaration of the Pretoria Seminar on Economic, Social and Cultural Rights in Africa, African Commission on Human and Peoples' Rights, 36th Ordinary Session held from 23rd November to 7th December 2004 in Dakar, Senegal. The Seminar was held in September 2004.)

[305] CESCR General Comment No. 14. (E.C.12/2004/4, 11 August 2000), pp 4 – 5, at para 12, see http://www.unhchr.ch/tbs/doc.nsf/(symbol)/E.C.12.2000.4.En .

[306] Article 12.

take into account the particular problems faced by rural women and to ensure that women living in rural areas have access to adequate health facilities. The obligations of States Parties towards rural women in particular is also emphasised in the Protocol to the African Charter on the Rights of Women in Africa."[307]

While ART and other essential treatments for people living with HIV and AIDS are available free of charge, as discussed further below these services are still mainly provided through hospitals. The circumstances of the women whom AI interviewed in KwaZulu Natal and Mpumalanga provinces indicate that women living in rural areas who do not have a secure income face serious challenges and in some cases complete inability to access treatment and ongoing care because they cannot afford the transport costs to get to the hospitals. Their ability to adhere to treatment is also jeopardised because they cannot afford adequate food with which to take ART twice daily. Although some of the women did receive temporary disability grants, food supplements or other social assistance for their children's welfare, their economic circumstances remained precarious and affected their ability to access or continue their treatment. In addition their access to health services is further compromised by systemic challenges within the health system, in particular shortages of staffing and delays in government implementation of aspects of the HIV and AIDS treatment programme, such as providing sufficient accessible health care facilities to provide ART.

Economic context: profiling poverty and unemployment

South Africa is still affected by great economic inequalities, which have a racial and gendered character, reflecting the legacies of the apartheid era, the complex impact of economic globalisation and, more controversially, government economic policies.[308] As noted by Chief Justice Pius Langa, "*…even today in our new dispensation, the ugly scars of systematic racial domination remain evident in unequal distribution of wealth; in the differing degrees of literacy and education; in the difference of infant mortality rates; in different standards of living*."[309] The persistence of poverty, the uneven if improving delivery of essential services to communities, shortfalls in the provision of adequate housing, a persistent high level of unemployment despite continuous economic growth since 1999, and the future direction of government economic policies have been subjects of vigorous public debate, community-level protests and political conflict within the ruling African National Congress during the past three or more years.[310] President Mbeki, at the opening of the South African parliament

[307] Article 14(2) (a).

[308] Hirsch A (2005); Makgetla NS (2007), pp. 146-167; Fig D (2007), pp. 226-244; Adelzadeh A (2007); UNDP (2003). The government's economic policies were a focus of criticism from within the ANC and by the party's trade union allies in the run up to the ANC's national conference in December 2007. The President appeared to be responding to these critics in his State of the Nation Address of the President of South Africa, Thabo Mbeki: Joint Sitting of Parliament, 8 February 2008. Available at: http://www.info.gov.za/speeches/2008/08020811021001.htm ; see also the budget speech of the Minister of Finance, Trevor Manuel, on 20 February 2008. Available at: http://www.info.gov.za/speeches/2008/08022016151001.htm .

[309] Lecture at Howard College, University of KwaZulu Natal, Durban, 9 October 2007 (*The Mercury*, 10 October 2007).

[310] On the socio-economic measures, see South African Government (2007); STATSSA Community Survey (2007), Section 6; Hirsch, A (2005), pp.233-255; Atkinson, D (2007), pp. 53-77; and Taylor Committee of Inquiry (2002), which refers to estimates of the number of South Africans living in poverty "at anywhere between 45 and 55 per cent", with Limpopo, Eastern Cape and Mpumalanga showing the highest poverty rates (p.29 and Figure 9).

on 8 February 2008, referred to some of these concerns and outlined steps in what he described as a "war on poverty".[311]

Black South Africans, in particular women, form the majority of those living below the poverty line, with the poorest households being headed by women, often in rural areas. According to the Presidency's Mid-Term Review in 2007, the proportion of the population living below a poverty line of R3,000 (US$397) per year had declined from 50 per cent in 1993 to 43 per cent in 2006, equivalent to some 20 to 21 million South Africans.[312] Although the expansion of state-provided "social grants" had helped lift the income of the poorest 20 per cent of the population, the Mid-Term Review acknowledged that rates of income inequality had increased. The share of total income of the poorest 20 per cent had declined to just under two per cent, and that of the richest 20 per cent had remained at just over 72 per cent.[313] Amongst the poorest 20 per cent were members of households in the "zero earned income" bracket. Forty-seven per cent of black women and girls were living in such households and many of them were totally dependent on state social assistance grants for survival.[314]

Large-scale unemployment is a persistent and politically sensitive issue, with South Africans of 'African' background having the highest unemployment rate and with women experiencing consistently higher rates of joblessness within each population category. The government's Mid-Term Review cited the rates for September 2006 as ranging between 25.5 per cent and just over 37 per cent of the working age population.[315] Geographically the highest concentration of unemployed workers was in the rural areas. Young men and women of 15 to 34 years constitute three quarters of all unemployed South Africans.[316]

While there had been some rise in women's share of employment and an increasing number of women, particularly white women, entering professional or other 'favourable' occupations after 1995,[317] a much larger component in the rise of women's employment was

[311] State of the Nation Address, 8 February 2008.
[312] South African Government (2007), p.23 Indicator 19. This proportion is equivalent to 20,952,000 of the population of 48.5 million reported by STATSSA Community Survey (2007), p.7. The political sensitivity of these measures, particularly prior to the ANC National Conference, was evident in the critical reactions by government to the South African Institute of Race Relations (SAIRR) report published on 12 November 2007, in which it was noted that the number of South Africans living on less than a dollar a day had increased to 4.2 million by 2006 and was closely related to the level of unemployment (see Letter from the President in *ANC Today* vol 7, No.45, 16-22 November 2007 (accessed at: http://www.anc.org.za/ancdocs/anctoday/2007/at45.htm) and SAIRR, Website Comment, 16 November 2007 (Available at: http://www.sairr.org.za/wsc).
[313] South African Government (2007), pp. 21 and 22, Indicators 17 and 18.
[314] These racial and gender proportions were reported by UNDP (2003), chapter 2, p.41 (Table 2.20), in which of those living below the "national poverty line", 92.4% were black South Africans of 'African' and 'Coloured' backgrounds; 50.9% were female; and 60.2% were single parents. UNDP (2003), p.21; Budlender D (2005), p.31; and Budlender D (2002). See also South African Government (2007), on evidence of increasing inequalities within "race groups" (p.22, Indicator 18).
[315] South African Government (2007), p.19, Indicator 15. The lower rate refers to the number of people seeking employment but who could not find any in the preceding two weeks; the higher figure refers to people who have been discouraged from seeking employment.
[316] South African Government (2007), p.19, Indicator 15; Pollin R et al (2006), pp.5-9; Hirsch A (2005), p.170 and 163-192 on the measures of unemployment used and analysis of the political context; Taylor Committee of Inquiry (2002), Table 2, p.20.; and UNDP (2003), pp.19-20. The SAIRR (2007) puts the unemployment figure at 4.2 million. The analytical categories used in employment statistics are still those of 'African', 'Coloured', 'Indian/Asian' and 'White'.
[317] Casale D and Posel D (2005), p. 22; Department of Labour (2007), Table 1, p.5, Table 4, pp.8-11, 48, 50 and 54.

derived "from the growth in work typically associated with low and insecure earnings".[318] Of the 1.4 million additional jobs recorded among women between 1995 and 2003, "more than 60 per cent were held by women either in self-employment in the informal sector," including through street trading, or in domestic work."[319] Consequently women's proportion of total earned income remained low, at 36 per cent, while at the same time the proportion of women who were primary income earners in their households was rising.[320]

A government committee of inquiry in 2002 emphasised that "an appropriate social security concept for South Africa must prioritize the needs of people without any incomes, with insufficient incomes, or who are engaged in the informal [economic] activities".[321] The Committee found that, notwithstanding "innovative and responsive" poverty relief projects promoted by government, these projects were not making a significant impact on the consequences of "mass based unemployment" and levels of income poverty, particularly for the poorest people in rural areas. As a result of these circumstances, they had "particular difficulties in accessing health care… because they do not have even the most basic income for transport…" [322] In this context the Committee considered the need for and feasibility of instituting a state Basic Income Grant.[323] Although there is still currently no form of social assistance for adults who are well enough to work but unable to find work, over eleven million people were in 2007 receiving social assistance grants, with just over three fifths in the form of means-tested child support grants for the main carer of children under fourteen years and just over ten per cent as disability grants.[324] A Southern African Catholic Bishops' Conference study of beneficiaries of social assistance grants found that 99 per cent of them used the grants to buy food and fifty per cent had no access to any other source of income.[325] The study also highlighted another concern, that despite the high degree of dependency on the grants for survival, many applicants had experienced obstacles and bureaucratic delays in obtaining access to the grants or necessary documents.

[318] Casale D and Posel D (2005), p.24.
[319] Casale D and Posel D (2005) refer to informal sector self-employment as including work such as trading, for example selling fruit and vegetables on the street, providing services such as hairdressing and child-minding, and small-scale farming. Pollin R et al (2006) note that those in "informal, non-agricultural employment accounted for a full 24.5 per cent of all employment" in 2005 (pp.7-8).
[320] Casale D and Posel D (2005), pp.22-28.
[321] Taylor Committee of Inquiry (2002). p.154. The Committee undertook its work in the context of Section 27 of the Constitution which provides that "[e]veryone has the right to have access to... social security, including, if they are unable to support themselves and their dependents, appropriate social assistance". To achieve the progressive realization of this right, the state is at the same time required to take reasonable legislative and other measures, within its available resources.
[322] Taylor Committee of Inquiry (2002), p.56.
[323] Taylor Committee of Inquiry (2002), pp.60-66. Their proposal for this universal grant has been actively debated since 2002, with support for it from a coalition of civil society organizations, and reportedly also the Minister of Social Development, but strong government reservations overall on its feasibility (Frank C (2006), p.92; Natrass N (2007), pp. 191-195; SACBC & CASE (2005), pp.4-5, 20-22; AIDS Consortium, "Some people would rather die of AIDS, than lose their disability grant" Press Release, August 2005; Sokomani A, Targeted social protection fuels welfare fraud, *Business Day*, 14 December 2007).
[324] STATSSA Community Survey (2007), pp.30-38 and Table 5.7 in particular. South African Government (2007), p.25 Indicator 21 where the total number receiving social-assistance support grants is stated as just over 12 million. See also Natrass N (2007), pp.179-181; Lund F (2007), pp. 78-79, 114-116; Hirsch A (2005, pp.246-247; Goldblatt B (2005), pp.239-257). These grants were being made to beneficiaries in terms of the Social Assistance Act (13 of 2004) and related regulations. See further below for discussion on the consequences of the criteria used for eligibility for disability grants.
[325] SACBC & CASE (2005), p.4.

Consequences of poverty for rural women living with HIV

Consistent with the evidence above that black women and residents of rural areas are disproportionately represented amongst the poor and unemployed, the women whom AI interviewed expressed anxiety and great frustration at their difficult economic circumstances. For the most part the areas in which the women lived in Mpumalanga and KwaZulu Natal are still affected by the extreme neglect and underdevelopment which resulted from the "separate development" policies of the apartheid governments.[326] Despite the women's manifest resourcefulness and aspirations to improve their lives and those of their children, their economic circumstances, AI found, would often act as barriers to access to treatment and care for HIV and AIDS.

A persistent feature of the women's circumstances was the almost total lack of access to the formal sector of the economy for employment and reliable income. At the conclusion of the interviews nearly all of the women told AI that their greatest wish was to find work. Among them was 28-year-old PY, from Mpumalanga, who said "*I most wish for a job, so I can build on my parents' house, raise my child and teach the community about HIV*".[327] ZT, who had experienced being verbally abused and abandoned by the father of her two youngest children in 2006, told AI that what she hoped for was "*to have a job, so that I will have money to maintain my children and to have my own place, without men*".[328]

For the most part the women survived through a variety of means, including dependence on partners or other family members, social grants or informal economic sector activities. One young woman earned a small monthly stipend doing community education work. Two-fifths of the women interviewed relied solely on income from child support grants to support themselves and their children.[329] Another fifth were supported by members of the family who received pensions,[330] or, in a few cases, their children who had managed to find work. One quarter of the women undertook street trading or 'piece work' on commercial farms, including 48-year-old JA who for the past five years had been supporting herself and her children by selling fruit and vegetables, after the death of her husband from AIDS-related illness.[331] Several of the women had had to give up their work in domestic service or as seasonal workers on farms because they had become too ill to continue.

SE, who had been abandoned by her husband several years earlier, was trying to raise her five children, ranging in age from six to 18 years, in a "*collapsing makeshift house*". She told

[326] Sideris T (2002); Sideris T (2005), p.117; Aliber M et al (2005); Makgetla N S (2007), pp.146-163.
[327] Interviewed on 5 May 2007 with the assistance of an interpreter.
[328] Interviewed on 4 May 2007 with the assistance of an interpreter.
[329] The grant is paid to the 'primary caregiver' of the child who is under the age of 14 to provide for his or her basic needs. The caregiver is subjected to a means test. A person living in a rural area can pass the test if earning less than R1,100 per month (US$146) or R13,200 per year (US$1,748). (STATSSA Community Survey (2007), p.36). In 2004 less than 1.5% of children registered for a grant had a male primary caregiver and 77% of registered primary caregivers were unmarried. By July 2005 the child support grant was reaching six million beneficiaries (Budlender D (2005), p.33; Goldblatt B (2005); Natrass N (2007), p.193). In 2007 the number of beneficiaries were nearly 7.2 million (STATSSA Community Survey (2007), p.37, Table 5.3.2). The Minister of Finance announced in his budget speech in February 2008 that the child support grant would increase by a further R20 by October 2008, so raising it to R220 per month [=US$29]. From January 2009 the child support grant will be extended to include children up to their 15th birthday.
[330] This is means-tested, non-contributory pension (Natrass, N (2007), pp.179, 193).
[331] Interviewed on 5 May 2007 with the assistance of an interpreter.

AI that her greatest wish was "*to have a home, beds,* [and] *blankets. He took everything when he left, even the kids' clothes.*" She had gone to the courts to try to secure maintenance from him, but without success, an experience suffered by many other women in South Africa.[332] Thirty-nine-year-old TN told AI that when the father of her children chased her away because he wished to live with another woman, she had tried to obtain maintenance from him for their children and eventually contacted his employer. The latter told her that he could not help unless she obtained a court order, but TN had no resources or information on how to approach the courts. She was trying to manage through goat-rearing, but had recently had to sell several to pay for the burial of her brother who had passed away from AIDS-related illness. She was now raising her late brother's children as well as her own.[333]

Three of the women who were living with HIV told AI that they were receiving disability grants, including 34-year-old PK, a widow who was also receiving child support grants for her four young children.[334] The disability grants, as defined under the 2004 Social Assistance Act, are intended to assist those who are unable to support themselves through employment due to a "physical or mental disability". Between 2001 and 2004 there had been an expansion of the numbers of people receiving this grant under the then existing legal framework. The explanations for this trend reportedly were due to an increase in the occurrence of chronic illnesses, most particularly HIV and AIDS, a raised awareness of the existence of the grant, along with a lowering of the threshold of the assessed seriousness of the condition for which the grant was awarded. In regards to the last reason, analysts have suggested that local level decision-makers had begun to allow the grant to be used as a form of poverty-alleviation. The proportion of beneficiaries diagnosed with HIV and AIDS rose from 27 per cent in 2001 to 41 per cent by 2003. By the latter year women constituted more than half of the grant recipients. Almost two thirds of beneficiaries reported earning no income.[335] In the view of one local decision maker, a medical officer from northern KwaZulu Natal, the increase in the number of disability grants in his area was due simply to "AIDS and poverty".[336] However, government took steps from 2004 to limit access to the grant to the purpose described in the Act. Consequently, once a person had recovered their health, or in the case of a person living with AIDS their CD4 count had risen above 200[337] and they were sufficiently able-bodied to work,

[332] Interviewed on 7 May 2007 with the assistance of an interpreter. The Maintenance Act obliges both parents, whether or not married, to share the financial costs of rearing the child. (Budlender, D (2005), pp.33-34). The Commission on Gender Equality reported from research undertaken on the Maintenance Court records that the monthly amount of maintenance ordered to be paid by absent fathers could be as low as R200 per child, although the father's median income was more than ten times the award. (See CGE (2004)). Other research has shown that women's ability to access the maintenance system can be jeopardised by poverty, cumbersome legal processes, lack of trained staff and infrastructure in the courts and women's fear of violence from former partners (Goldblatt B (2005), p.250; Lund F (2007), pp.37-38 citing the work of South African researcher Debbie Budlender).

[333] Interviewed on 7 May 2007 with the assistance of an interpreter.

[334] Interviewed on 7 May 2007 with the assistance of an interpreter.

[335] CASE (2005), pp.2, 13-16, 55-77, 109-110, 115-120. The research was commissioned by the National Treasury and the Department of Social Development. See also Natrass N (2007), pp.181-185.

[336] Quoted in CASE (2005), p.96.

[337] In the healthy person the CD4 T cell count should be higher than 500 cells per millilitre of blood. Counts marginally above 200 do not indicate a return to health and recent treatment guidelines issued in Europe and the USA have recommended a threshold of 350 cells/mL for the commencement of antiretroviral medication. See: Department of Health and Human Services Panel on Antiretroviral Guidelines for Adults and Adolescents. *Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents, December 1, 2007*. Available at: http://aidsinfo.nih.gov/contentfiles/AdultandAdolescentGL.pdf.

then they would no longer receive the grant.[338] However many would be unable to find work, making the loss of the grant a serious blow for the person living with HIV and AIDS and often other family members who depended on the same grant for survival.[339]Forty-nine-year-old IM, who was responsible for a severely disabled child, lamented that

> *"I am not working at all* [and] *it is very difficult to get the grant. Here in South Africa there's a grant for some people whose CD4 count is less than 200 and my count is up.* [But] *I can't see. I just use one eye. The doctor says it's the virus that causes that, but they say that because you've got another eye you can use that other one…So it's very difficult."*[340]

Lack of access to adequate food

> "*I take my medicine with food, but it is very difficult at times as there is no food because no-one works; but I manage to eat a little something with my medicine".*[341] (Testimony of LK, a woman living with HIV in rural KwaZulu Natal)

The UN CESCR has interpreted the right to health as including underlying determinants of health, such as an adequate supply of safe food.[342] This gains even more significance for people living with AIDS where access to adequate food daily is essential for coping with the side effects of antiretroviral medication. The energy requirements of HIV-infected individuals increase by about by 20 to 30 per cent when chronic opportunistic infections or HIV-specific conditions begin to be felt.[343] Consequently the WHO recommends that they should be assured of at least one recommended daily allowance of most vitamins. "In the absence of an adequate diet, this often means that HIV care and treatment programmes must supply multiple micronutrient preparations."[344] In addition, there are further considerations for an HIV-infected person who has progressed to the stage where she/he needs to be placed on an ART programme. Antiretroviral medication, which has strong effects on the user and may in some cases cause serious side-effects, needs to be taken with food at regular intervals – most commonly twice a day – for the remainder of that person's life. For many rural women living in precarious economic circumstances, the lack of access to adequate food remains a barrier to their realization of the right to health.[345] The AIDS Consortium in South Africa has expressed concern that "[i]n many cases of extreme poverty, the balanced nutrition and sufficient food that are essential to support antiretroviral treatment are not guaranteed."[346] The AIDS Consortium has stated that "basic food security is essential". They warned that "[u]nless at

[338] Although the Mid-Term Review shows a steady increase in the number of disability grant recipients from 1999 (633,778) to 2007 (1,429,593), the latter figure appears to be a cumulative total of all current recipients as of April 2007, and the proportions of different categories of disability grant recipients are not disaggregated (South African Government (2007), p.25, Indicator 21).
[339] Taylor Commission (2002), pp.102, 104, 105.
[340] Interviewed on 7 May 2007 with the assistance of an interpreter. The grant amount is R780 (US$103) per month (Natrass, N (2007), p. 193).
[341] Interviewed on 7 May 2007 with the assistance of an interpreter.
[342] General Comment No.14, p 3, para 11.
[343] Rollins N (2007), p. 1576, citing the WHO standards.
[344] Rollins N (2007), p.1576.
[345] Sections 27(1) (b) and (2) of the Constitution guarantee the right to have access to "sufficient food and water" and obliges the state to progressively realize this right.
[346] AIDS Consortium (2006), p.5.

least some food is available for each dose, the side effects of treatment or non-compliance with treatment can do more harm than good".[347]

A medical practitioner involved in HIV clinical programmes in Mpumalanga province observed that "with the [disability] grant, [patients] are able to buy basic food that is necessary to complement antiretroviral treatment. After the 12-month deadline the grant expires, patients start to become depressed and they start developing side effects to their treatment since most of them have to take their medication on an empty stomach. Without the grant you find that the patient's CD4 counts drop and they start becoming very ill again".[348] Some researchers and advocacy organizations have also noted another alarming indication of desperation, in anecdotal evidence of patients actually stopping their treatment in order to stay on the grant.[349]

The women whom AI interviewed commonly experienced shortages of food and described their difficulties in securing the food required to take with their medication. Fifty-five-year-old RU had discovered her HIV-infected status at the time of the birth of the youngest of her four children. Her husband had left her and she had managed, while in reasonable health, to support herself and the younger of her children with gardening and other piece jobs. She told AI that she had never missed her twice daily ARV medication which she would take even if she had no food.[350] When there was not enough food in the house, she would go out and collect *imbuya*, a bitter-tasting wild spinach. *"Even when I do not have food, I still take the tablet, but I feel more comfortable when I have food to take with it."* And thirty-two-year-old LK, who started taking ARVs in February 2007, commented that "*I take my medicine with food, but it is very difficult at times as there is no food because no-one works; but I manage to eat a little something with my medicine"*.[351]

Several of the women became very distressed when describing their daily struggle to find food, among them, TI who had carer responsibilities for the children of her late sister following her death from AIDS-related illness. She started crying when asked if she worried about not having enough food for the household. At least one of the older children was HIV-infected and had become very ill. Every day TI faced her sister's children without food to offer them, she told AI.[352] She was unable to have access to child support grants as the birth certificates and other identity documents needed for the applications had been lost. A local support organization, however, was trying to assist her to be appointed legally as the

[347] AIDS Consortium (2006), p.5. At the 4th meeting of the JCSMF in May 2005, participants concluded that "critical treatment such as ARVs may not achieve its full benefit without appropriate and adequate nutrition" (Accessed on: http://www.jcsmf.org.za/?q=node/9).
[348] Quoted in TAC, *Equal Treatment*, December 2005. The medical practitioner concerned had been working in the public health sector for some time to increase the accessibility of ART at non-hospital sites to patients who could not afford transport to hospitals (AI interviews in Nelspruit 3 and 4 May 2007).
[349] Natrass, N (2007), pp.184-187, 197-198; AIDS Consortium, "Some people would rather die of AIDS, than lose their disability grant", Press Release, 15 August 2005; AI interview by phone with AIDS Consortium 6 November 2007.
[350] Interviewed on 7 May 2007 with the assistance of an interpreter.
[351] Interviewed on 7 May 2007 with the assistance of an interpreter.
[352] Interviewed on 10 May 2007 with the assistance of an interpreter.

children's foster mother, in the hope that this would allow them to have access to foster-care grants and assistance for school-related costs and food.[353]

Rural women's low social status also compounded the problem of limited access to adequate food. Several of the women in polygynous marriages and living at the homesteads of their husbands' families told AI that they were often the last to receive food at family meals. TH, who took her meals with 12, and sometimes 20, other members of her husband's family, told AI that there were periods of food shortages. She added that she would be the last to receive food for *"I am at the lowest end of all."*[354]

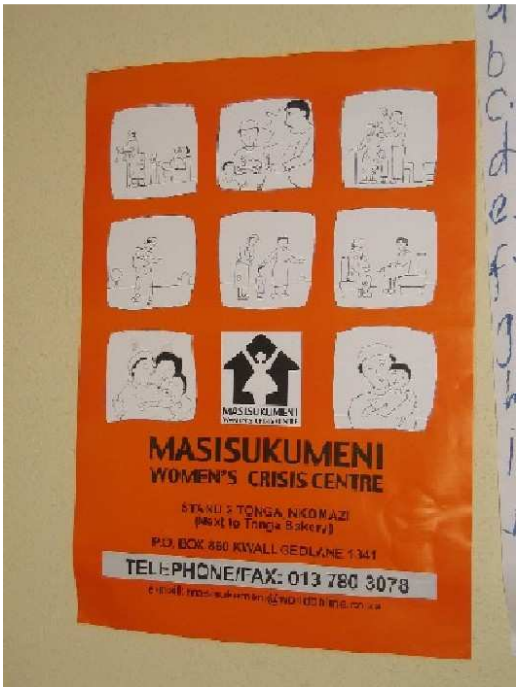
One local NGO assisting some of the women whom AI interviewed was trying to secure funds to enable the organization to continue providing food supplements to those women who were able to travel to the NGO centre or at least able to reach local support groups. The provincial Department of Health funded the cost of the supplements, but not the distribution costs. There is provision in national and provincial budgets for "nutrition supplementation intervention" for people with TB and HIV. In particular, people living with HIV and AIDS, who are or should be on ART but do not have access to a food supply, are eligible to receive supplement meals. At least one of the women whom AI interviewed, LE, who was living with HIV, was being assisted by a state scheme following her diagnosis with TB. She still struggled though, commenting that "*there are times when there is no food* " [355]

Health rights advocacy groups and health care providers have expressed concern in the past that the programme was under-budgeted, that food parcels and supplements were not available for those eligible at all clinics, and access to this form of support was made more difficult by the shortage and under-training of social workers who have to assess eligibility.[356] The government, in its mid-term report on progress in achieving the MDGs, confirmed that nutritional supplementation is "provided to people living with HIV and AIDS, TB and other debilitating conditions." The number of people receiving the supplements was reported to have increased by a fifth to over 80 per cent in the preceding two years.[357] The report does not make clear the proportion of those accessing the supplements who were living with HIV and AIDS, nor what proportion were located in rural areas. The circumstances described to AI by some of the women in KwaZulu-Natal and Mpumalanga suggests that information about these state-funded programmes was not reaching them or that they faced obstacles in accessing them.

In recognition of the impact of intractable, large-scale unemployment on families living with HIV, the NSP included as a necessary intervention the introduction of "sustainable

[353] A "foster child" is a child who has been placed in the custody of foster parents as a result of being orphaned or abandoned or at risk or neglected. Anyone who is not the biological parent who looks after such a child can apply to become a legal foster parent at a Children's Court. The grant is subject to a means test (STATSSA Community Survey (2007), p.36).
[354] Interviewed on 7 May 2007 with the assistance of an interpreter.
[355] Interviewed on 7 May 2007 with the assistance of an interpreter.
[356] JCSMF(2005) (Available on: http://www.jcsmf.org.za/?q=node/9)
[357] South African Government, Millennium Development Goals Mid-Term Report, September 2007, p.29. This section of the report was done under Goal 6, Target 7 referring to combating and reversing the spread of HIV and AIDS. (Available at: http://www.thepresidency.gov.za/main.asp?include=docs/pcsa/social/millenium.html

income transfer to poor families."[358] In responding to this challenge government authorities have to uphold their obligations, first of all, to progressively realize the right to health for all without discrimination. They need to take into account, in addition, the life-long needs and health consequences of HIV infection for women who are living in circumstances of chronic poverty. The provision by the state of a number of social assistance grants has been critical for the survival of individuals and families living with HIV and AIDS in circumstances of poverty, but the limitations imposed by current eligibility criteria can result in women still being denied access to health services and to adequate food due to their inability to find other secure income. The NSP recognized this problem and included as a requirement for the effective implementation of the plan, the strengthening of systems to provide food support and the introduction of a "chronic diseases grant".[359]



NGO Service-providing organisations play a vital role assisting women with information on state services and helping them cope with the consequences of violence and other forms of discrimination. © AI 2004

There may be other interventions which are long-term and sustainable, to help ensure that economic barriers to accessing health services and overcoming food insecurity are addressed.[360] Microfinance projects could be one such intervention which may assist women who are living with HIV but are effectively shut out of the formal economy although still well enough to work or could be after some period on ART.[361] Certainly the women whom AI interviewed in KwaZulu Natal and Mpumalanga provinces had expressed strong desires to improve their skills, to find work in the formal sector or continue to do what they could with income-generating activities in the informal sector. The project in Limpopo province known as the Intervention with Microfinance for AIDS and Gender Equity (IMAGE), which ran from 2001 to 2005, is reported to have shown promising results. Over 70 per cent of participants, who came from a poor rural area in the province, had reported at the start of the project having had to beg for food or

[358] NSP (2007), p.61.
[359] NSP (2007), p.147.
[360] The AIDS Consortium had recommended strengthening the role of the community health workers to deliver medication and also food parcels to those too sick to travel at all (Press Release 15 August 2005).
[361] Pronyk PM et al (2007), pp.1925-1927.

money in the preceding year. During the lifetime of the project some 1750 loans valued at more than US$290,000 were disbursed to the women and used mainly to support retail business initiatives, with a 99 per cent repayment rate.[362] Promotion of similar projects would require strong and sustained government and donor support.[363] In his address to parliament in February 2008, President Mbeki acknowledged the need to intensify efforts to increase assistance to small business enterprises, "especially those involving women", as part of an "anti-poverty strategy".

Accessibility of health services: distance and transport costs as barriers

> *"I should have returned in March for a further CD4 count, but I was unable to find the money for transport."* (Testimony of ND, who was living with HIV and had drug-resistant TB, in KwaZulu-Natal)[364]

The UN CESCR has emphasised that health facilities, goods and services must be physically accessible, by being within safe physical reach for all sections of the population, including in rural areas.[365] These services must also be affordable for all, including socially disadvantaged groups.[366] "States have a special obligation to provide those who do not have sufficient means with the necessary health insurance and health-care facilities".[367] The State's obligation to ensure equitable distribution of all health facilities, goods and services has been identified as a 'core obligation'[368] by the CESCR, which means that its realization should be an immediate priority.[369] The Protocol to the African Charter on the Rights of Women in Africa also requires that "all appropriate measures" should be taken to "provide adequate, affordable and accessible health services, including information, education and communication programmes to women especially in rural areas."[370]

In South Africa however, as the roll-out of the ART programme is still predominantly being conducted through hospitals, health services for HIV and AIDS can be inaccessible to many rural women due to transport costs and distances. The South African Human Rights Commission (SAHRC), in its 2007 review of aspects of health services in the provinces, particularly noted that poor road conditions, long distances, infrequent transport and its high

[362] Kim J et al (2007), pp.3, 6-7, 11; Pronyk PM et al (2006), pp.1973-1983. The study project received financial support from a range of organizations, including business corporations, foreign government development agencies, international non-governmental donors and the Limpopo Department of Health and Welfare.
[363] The Office of the Premier of KwaZulu Natal informed AI that income generating projects are seen as part of a gender-sensitive response to HIV and AIDS in the province (AI interview by phone 12 February 2008).
[364] Interviewed on 7 May 2007 with the assistance of an interpreter.
[365] General Comment No.14, at para 12. available at: http://www.unhchr.ch/tbs/doc.nsf/(symbol)/E.C.12.2000.4.En.
[366] General Comment No.14, at para 12.
[367] General Comment No.14, at para 18.
[368] The CESCR has clarified that each State party, notwithstanding its level of economic development, is under a minimum core obligation to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights found in the ICESCR. The Committee has stated that "in order for a State party to be able to attribute its failure to meet at least its minimum core obligations to a lack of available resources, it must demonstrate that every effort has been made to use all resources that are at its disposition in an effort to satisfy, as a matter of priority, those minimum obligations". General Comment No. 3 (E/1991/23, 14 December1990), para 10.
[369] General Comment 14, at para 43.
[370] Article 14(2) (a).

costs (relative to income) hinder patients' access to these services at the hospital level. The report concluded that "the poorest and most vulnerable members of society are frequently excluded from accessing higher levels of care…" for these reasons.[371] These barriers to access are compounded for HIV and AIDS patients where only a small number of health care facilities have been accredited to provide ART in rural areas.[372] One Eastern Cape provincial study in 2007 highlighted the serious transport barrier for some HIV patients who lived up to 200 kilometres from the nearest accredited treatment centre.[373]

AI was informed, during a visit to a rural Mpumalanga hospital in 2004 after the ART roll-out had begun, that a patient's ability to keep regular appointments was among several key requirements, apart from clinical indications, which a person had to meet before being started on ART. As one of the doctors frankly expressed it,

> *"…if patients are too poor to attend hospital regularly because they cannot afford transport here, and we have not the transport to bring them here or the means to distribute the drugs in another way, then we cannot treat them."*[374]

ART treatment programmes require patients to visit the hospital for a number of preparatory sessions before beginning treatment, to ensure that patients understand the nature and the effects of the medication and the importance of adhering to treatment every day. Patients are also required to disclose that they are on treatment to a friend or family member, to ensure that they receive a minimum level of support to assist adherence. For the women whom AI interviewed, once on treatment they needed to visit the hospital on a monthly basis to collect their medication and to have any side effects monitored. All of this increases the amount of travel required for them and the cost of remaining on treatment. This challenging situation for patients without secure income highlights the importance of having in place support systems to enable them to have regular access to health services and to adhere to treatment.

Many of the women whom AI interviewed were in need of medical attention, several urgently so, or they had been told to return to the hospital or clinic but found it difficult to undertake the journey due to their economic circumstances. Some women reported that they needed to collect their CD4 count results, which determine when a person living with HIV should begin ART, or had to go to the hospital for their scheduled monthly visit to collect their ARV medication, but could only do so if they were able to borrow the transport money. Among them was thirty-two-year-old LK,[375] who depended on two child support grants to support her family. She told AI that to collect her ARVs, *"I have to go to the clinic once a month. It is R40* [US$5] *return. I have to borrow the money every way I can."*

Another young woman was facing similar problems. Twenty-four-year-old LE, who was supporting herself by selling fish in the local market, had visited a mobile clinic to take an

[371] South African Human Rights Commission (2007), pp.3, 21, 35.
[372] See further below.
[373] Odendal L (2007), pp.14, 23-24, 27. The hospital in question had available only one eight-seater patient transport vehicle twice a week.
[374] AI interview conducted on 20 August 2004.
[375] Interviewed on 7 May 2007 with the assistance of an interpreter.

HIV test. She had tested positive and the staff provided her with a letter to take to a particular Primary Health Care facility 90 minutes away by public transport. There they provided her with immune boosters, she told AI. Six months later, in January 2007, she was diagnosed with tuberculosis at the same clinic. At the time of the interview she was finding it difficult to go back to check the results of her CD4 count because of the transport costs.[376]

ND's story[377]

Twenty-six-year-old ND, who as the oldest of six siblings had the responsibility for caring for them as well as her own seven-year-old son, had undergone tests at a hospital to see if she needed to commence treatment for AIDS. The last time ND was able to go was in January 2007. She told AI that *"I should have returned in March for a further CD4 count, but I was unable to find the money for transport."* The cost of the transport was R30 (US$4).

She told AI that she had been suffering from tuberculosis (TB), a common opportunistic infection in people living with HIV, for almost two years now. None of the medication she received had provided a cure, indicating that she had a drug resistant type of TB.[378]

ND's partner, the father of her child, had died in 2006. "*My boyfriend and I tested together in 2004. My parents are also dead, of HIV"*, she added during her interview with AI. She lived together with her siblings and son in one room made available to them by an aunt. None of them had a stable income. However one of her sisters also had a child and so ND and her sister supported the entire family of six adults and two children on the money they received from two child support grants -- a total of R400 (US$52) per month. She managed to eat only once a day and described obtaining food as a persistent problem. Adding to her distress were difficulties with her siblings; they did not treat her well; there were arguments and they had been talking about her HIV-infected status in the community. She told AI that she wished she had funds to help her further her education and secure a job.

AI's findings are consistent with the view expressed by the South African Human Rights Commission, that "poor physical access is tantamount to a denial of access to health care services".[379] According to the testimonies of the women whom AI interviewed, due to lack of the equivalent of less than ten US dollars for transport, they were sometimes unable to have access to hospital and some clinic-based health services for HIV and AIDS or could do so only by borrowing money. This precarious situation was a source of great anxiety for them. In South Africa patients in the public sector are not required to pay for ART, which is a key

[376] Interviewed on 7 May 2007 with the assistance of an interpreter.
[377] Interviewed on 7 May 2007 with the assistance of an interpreter.
[378] Rates of multi-drug resistant tuberculosis (MDR-TB) and extensively drug-resistant TB (XDR-TB) are increasing in South Africa, in particular in KwaZulu Natal province and in a manner indicating an evolving epidemic and with high death rates (Andrews JR et al (2007), Gandhi NR et al (2006)). TB case notifications had increased from 90,292 in 1994 to 315,315 in 2006, with a country-wide "cure rate" of about 56 per cent, but with some districts of KwaZulu Natal and Mpumalanga achieving below 40 per cent (South African Government (2007), p.39, Indicator 35). South Africa, globally, is among the ten countries with the highest prevalence of TB and HIV co-infection (APHRA (2007). Co-infection with HIV and TB "presents serious medical and scientific challenges, among them difficulties in diagnosis, infection control and managing co-toxicities between drugs previously used to independently treat the two diseases" (HIV-TB Report, 2007), difficulties which are compounded in cases of drug-resistant TB, with a difficult balance to be maintained between effective infection control and the patient's human rights (Basu S et al (2007) and Singh JA et al (2007); see also "Dilemma as SA faces drug resistant TB epidemic" (*Mail&Guardian*, 27 January 2008) and "XDR-TB may be bigger risk than Aids" (*Pretoria News*, 11 January 2008).
[379] South African Human Rights Commission (2007), p.3.

factor in ensuring patient retention in treatment programmes.[380] Free health care has been extended to all South Africans using the public primary health care facilities, while payment for services at hospital level is means-tested. Indigent citizens are entitled to receive free services.[381] However the effects of this free provision of life saving medicines and services appear to be undermined for rural women by the difficulties they face in securing stable incomes sufficient to ensure that they have access to adequate food and affordable transport.[382]

The NSP includes transport as one of the basic social services for which there should be "equitable provision", as part of the goal of reducing the impact of AIDS by strengthening "safety nets [to] mitigate the impact of poverty".[383] The women's testimonies provide evidence that their right to have access to health services is not being fulfilled, because the services are not physically and economically accessible to everyone without discrimination. The barrier of transport costs needs to be addressed as a matter of urgency by government at national, provincial and municipal levels, whether through some system of subsidized or free transport, or patient grants to cover transport costs or other measures which do not have the effect of stigmatising those who may use such systems or do not impact negatively on the right to access health care services of others. Non-discriminatory access could also be increased by expanding HIV services as much as possible at the local level (see below).[384]

Availability and accessibility of health services: barriers to treatment and care

> *"There is international consensus that without urgent improvements in the performance of health systems, including significant strengthening of human resources for health, the world will fail to meet the Millennium Development Goals for health or to achieve universal access to HIV services by 2010"*. [Dr Margaret Chan, Director-General of the WHO] [385]

> *"I did explain and they said try and get the money. But I cannot get the money"*. [Testimony of KE, who was suffering AIDS-related illnesses and unable to reach the nearest hospital to start ART.]

The UN CESCR has identified the availability of functioning public health care facilities in sufficient quantity, including trained medical and professional personnel receiving

[380] Rosen S, Fox MP, Gill CJ (2007), where the authors note that the retention rates for South African patients in various treatment programs ranged from 62.2% to 90.3% over a median follow up period from 12.3 to 19.5 months. The overall average retention rate in the multi-country study was 60%. The national treasury allocation to the National Department of Health and the provincial departments of health (through "conditional grants" for HIV/AIDS treatment and other programs), along with provincial level discretionary funds, provide the bulk of the budget for HIV and AIDS prevention, treatment and support programs, The national government procures the antiretroviral medicines used in the public health sector from pharmaceutical companies (in 2007 there were seven companies on three-year supply contracts with government). Some additional funds are also provided by the Global Fund for HIV/AIDS, TB and Malaria and bilateral donors such as PEPFAR and NGOs such as ARK and MSF (Business Day, "Call for Consultation in Aids-Drug Contracts (22 January 2008); ISS-TI (2007), pp.22-28; Ndlovu N (2005); Hickey A 2003a and 2003b).
[381] Taylor Committee of Inquiry (2002), p.85.
[382] See the observations of UNAIDS on this point in Piot P et al (2007).
[383] NSP (2007), p.61.
[384] See further below for discussion on decentralisation of HIV services.
[385] WHO (2008), Preface.

domestically competitive salaries, as an essential element of the right to health.[386] However, in South Africa there is widespread agreement that the country's hospitals and clinics are experiencing a severe shortage of trained health care professionals, particularly in rural areas. In addition, and more controversially, there are "bottlenecks" in the certification (accreditation) of sufficient numbers of health care facilities to provide ART. Both these problems have a direct impact on the availability and accessibility of health services for people living with HIV and AIDS, especially where they are living in circumstances of poverty and at considerable distance from treatment centres. Increasingly health care providers both within the public health sector and the donor community have recognized the need to implement ART clinical programmes at non-hospital sites and involving the use of "task-shifting" among health workforce teams, in conjunction with community support groups, in an effort to reach the goal of universal access. At the same time urgent steps should be taken to systematically identify and close the gaps in staffing required to successfully deliver the national strategic plan.

Staffing crisis

Following the introduction of ART in the public sector in 2004,[387] the "roll-out" of treatment had slowly expanded to include, by May 2007, a "cumulative total of 303,788 patients", according to the government's mid-term report on the MDGs, at 316 sites across the country.[388] Health rights monitoring organizations, however, noted in April 2007 that an estimated 717,000 people needed treatment.[389] The service is provided mainly through hospitals and requires a doctor to initiate and monitor a patient on treatment. Hospitals in South Africa have had to overcome the legacies of a racially fragmented and grossly unequal health system and are currently experiencing severe shortages of medical and nursing staff, particularly in rural areas. The National Department of Health (NDoH), in its human resources plan issued in 2006, acknowledged that "the health system faces the task of attracting health professionals to rural and other under-served areas" and that the "staffing of most rural hospitals remains a problem, and hospitals in remote rural areas still lack doctors".[390] As noted by health systems researchers, "[t]he poor availability of health personnel, particularly in the geographical areas of greatest disadvantage, has emerged as one of the most significant constraints to improving access to health care in South Africa".[391]

[386] General Comment No.14, p 4, para 12.
[387] The roll-out of ART was undertaken with the parameters of the Operational Plan for Comprehensive HIV & AIDS Care, Management and Treatment, November 2003.
[388] South Africa Government, Millennium Development Goals Mid-Term Report, September 2007, p.29.
[389] Hassan F (2007), p.104, where the number of those on ART was stated as just over 257,000. The author notes that about one third of these patients receiving ART were supported by donors such as PEPFAR, MSF and ARK. In addition, according to AIDS Law Project research, between 100,000 to 110,000 other people were on treatment in the private and not-for-profit sectors (ibid). The JCSMF has shown that the gap between the numbers receiving treatment and the number targeted for treatment had steadily grown to 36% by February 2007. ("SA ART Programme treatment gap", available at http://www.jcsmf.org.za/files/arv%20data%202007.gif .) See also the analysis of the treatment waiting-list situation in the Eastern Cape Province in Odendal L (2007), where the actual numbers of those needing treatment could be underestimated because of the staffing incapacity at the clinic level where VCT services were being provided (pp.5, 15).
[390] NDoH (2006), chapter 2, pp.22; Schneider H et al (2006), pp. 17- 20; Schneider H et al (2007), p.298.
[391] Schneider H et al (2007), p.298.

There is a direct correlation between the number of people with access to health services and the number of health service providers, according to the WHO.[392]

While public health expenditure is reported to have increased since 1994, it has apparently not kept pace with the increasing number of people, amounting to about 84 per cent of the population, needing to use services in the public health sector. In addition there is a striking inequity in the levels of expenditure in the public and private health sectors. According to NDoH information in 2005, private sector expenditure was nearly 13 per cent higher than in the state sector, despite the former providing services to only 16 per cent of the population. Half of South Africa's nurses and two thirds of its doctors are working in the private sector. In 2007 the extent of the inequity in access to health care providers was evident in the ratios of medical practitioners per population served: within the public sector it was one per 4,219, while in the private sector it was one per 601.[393] State expenditure has also not kept pace with the impact of the "extraordinary additional disease burden" from HIV and AIDS, and has not always been effectively deployed, according to health systems researchers and advocacy groups.[394]

Médecins Sans Frontières (MSF), in referring to the Southern African sub-region, states that the "lack of health staff is a deadly impediment to expanding and sustaining antiretroviral treatment and must be confronted as an emergency…".[395] South Africa shares with other countries in the sub-region difficulties in retaining appropriate levels of trained health personnel, including through the impact of international recruitment of health care providers by countries with more developed economies.[396] Between 1996 and 2003, supply of doctors in provincial health services declined by 24 per cent and of nurses by 16 per cent. The NDoH referred to "dramatic declines in public sector personnel" and that the "decrease in the number of professional nurses in most provinces" was a threat to "the core of health service delivery" and had to be addressed "as a matter of urgency".[397] During the same period there was a decline by 35 per cent in nurses undergoing professional training in South Africa, with only a minority of those trained working in the public sector.[398] The shortages have been experienced

[392] WHO (2008), p.6.
[393] Health Systems Trust (2007), p. 143-144; see also NDOH (2005), paras 2.1.6b and 2.2; NDOH (2006), chapter 2, p.30; Schneider H et al (2007), pp. 296-297; MSF (2007), p.8; Africa Public Health Rights Alliance (APHRA) (2007), p.2 (Table on health expenditure profile of countries with highest overall TB prevalence in Africa).
[394] Schneider H et al (2007), pp.296-297, and noting also that HIV and AIDS contribute 29.8% of all deaths in South Africa (p. 301, Table 12.2 using data from 2000); ALP, NEHAWU and TAC (2007); Holdt VK, Murphy M (2007), pp.315-318, 329-332; Odendal L (2007), pp.6-7, 16-17. Hickey A (2001 and 2003b) noted the poor capacity initially at provincial level for planning and using "conditional grant funds" for HIV/AIDS programs from national treasury, and in addition considerable variation in expenditure levels within the provinces, using conditional and discretionary funds, on HIV/AIDS health interventions, with the Western Cape spending the most and Mpumalanga the least per AIDS-sick person (Hickey A (2003a)). The latter province had spent less than 40% of its conditional grant in 2003, compared with KwaZulu Natal 100% and the Western Cape 98% (Hickey A (2003b). These two provinces also topped up their conditional grant allocations with a higher proportion of discretionary funds, with KwaZulu Natal at 54%, Western Cape at 29%, compared to Mpumalanga at 16% of total (Ndlovu N (2005)).
[395] MSF (2007), p.19.
[396] WHO (2008), p.6.
[397] NDoH (2006), chapter 3, p.35.
[398] Schneider H et al (2007), pp.298-299 and Tables 12.2 and 12.3; and ALP, NEHAWU and TAC (2007), paragraph 3.2 referring to the steady decline in the number of nurses in the public sector since 2000. MSF (2007), p.9. Daily News, 'Nursing Situation Disastrous' (8 November 2007), quoting Francois Steyn of the University of the Free State that only 2,508 of the 7,000 nurses graduating between 2003 and 2006 were working in the public sector.

also in other categories important for managing HIV and AIDS, including pharmacists and dieticians.[399] The staff shortages appear to have resulted from, among other things, training deficits, the impact of HIV and AIDS directly on the health care providers and on working conditions, high stress levels, protracted recruitment processes to fill vacancies or poor human resources planning, salaries which were uncompetitive with the private sector and emigration.[400]

The prevalence of HIV among health workers in South Africa is similar to that prevailing in the community at large.[401] The health sector consequently has faced significant losses of health workers as they get sick. In addition these circumstances have a negative effect on the morale of remaining staff, having lost colleagues and facing an increased work load. Studies have shown that the impact of HIV has been linked with stress, burnout, absenteeism, and decline in quality of health services.[402] The WHO refers to a "vicious circle" in which the epidemic fuels the health workforce crisis while the shortage of health workers represents a major barrier to preventing and treating the disease.[403] These effects for health care staff would have been exacerbated by the government's delays in adopting and implementing effective treatment regimes for HIV-related opportunistic infections and AIDS.[404] These deteriorating circumstances would have contributed to the pressure on staff to emigrate which is driven principally by economic factors and working conditions.[405]

In their submission to the South African Human Rights Commission, health rights advocacy groups drew attention to the declining numbers of nursing staff per 100,000 public health sector users over a five-year period from 2000. They expressed concern that the declines in staffing ratios were "symptomatic of the absence of any reasonable [human resource] planning," most particularly in relation to the increased demand caused by and the direct effects on the workforce of HIV and AIDS.[406] The NDoH's human resources plan of 2006 acknowledges a variety of pressures contributing to the poor retention rates of health personnel, but only very briefly alludes to HIV as one of a number of disease trends which pose human resource challenges.[407] The Minister of Health acknowledged, in a speech at an African Union meeting in 2007, that attempts to introduce retention measures such as by improving salaries and conditions of service, and entering into bilateral agreements to stop

[399] AI interview with staff at DoH KwaZulu Natal province (by phone), 11 February 2008.
[400] NDoH (2006) in its discussion of factors contributing to the staffing deficits noted "the poor salaries being paid to health professionals in addition to high workloads" and the impact of increasing migration of health personnel (chapter 2, pp.27, 31). NDoH (2006) added to this the impact of uncompetitive salary levels and working conditions relative to the private sector which affected staff retention and encouraged migration. (chapter 3, pp.48-49).
[401] Shisana O et al (2003 and 2004).
[402] Dovlo D (2007).
[403] WHO (2008), p.6.
[404] Schneider H et al (2007), pp.302, 306; Stein J, et al (2007), pp.956-957.
[405] Awases M et al (2004); Schneider H et al (2006), p.18. Professional emigration has been driven both by domestic lack of resources (a "push" factor) and by policies of developed countries which actively welcome foreign graduates to supplement locally trained personnel (a "pull" factor"). See PHR (2004) and Bueno de Mesquita J and Gordon M (2005). The UK introduced a code of practice for international recruitment of health personnel (UK Department of Health, 2004) though such codes have been criticised as being ineffective and restricting the human rights of those seeking to work abroad (Klingma, 2006).
[406] ALP, NEHAWU and TAC (2007), pp. 8-9, citing figures from the Health Systems Trust, *South African Health Review 2005*.
[407] NDOH (2006a), p.31.

recruitment from abroad, had had only limited impact.[408] On a separate occasion the Minister also acknowledged that the staff shortages had a negative effect on efforts to expand the number of health care facilities able to provide ART.[409]

During its visit in May 2007, AI heard complaints that delays in completing recruitment processes by provincial departments of health were continuing to contribute to a significant number of unfilled posts in hospitals, particularly in Mpumalanga province.[410] For a variety of reasons, the scale of unfilled professional posts in the South African public health sector is very high, and in 2003 was over thirty per cent vacancy rate.[411] In the same year, the individual provinces showed differences in the levels of vacancies, with Mpumalanga having the greatest difference between the number of public health sector posts (19,018) and the number filled (6,201 or only thirty-three per cent). KwaZulu Natal had 76 per cent of its posts filled in the same year, and the Western Cape over 86 per cent.[412] The NDoH's human resources plan acknowledges that there is an urgent need to improve human resource management and decision making on recruitments within provincial departments of health.[413] In January 2008 the South African Medical Association (SAMA) publicly expressed alarm that four district hospitals in Mpumalanga province had closed their after-hours emergency services due to a shortage of medical officers, with a direct impact on continuity of patient care and availability of emergency treatment and care for new cases including victims of sexual assault. The shortfall had partly arisen as a consequence of changes made to the medical internship (Community Service) programme in 2006. SAMA noted that it had advised the NDoH in 2007 of measures which provincial departments of health could take to minimise the effects, but that Mpumalanga's Department of Health, in contrast to other provinces, had failed to act on the advice.[414] Several weeks later, on 11 February, the national Minister of Health announced that she had set the provincial department a six-month deadline to fill all vacant advertised posts and that authority related to financial and human resource decisions had to be decentralised.[415]

The impact of staffing shortages for people's ability to have access to health services was evident at the start of the ART roll-out. In 2004, during a visit to a rural Mpumalanga hospital, AI had been informed that 50 people had started ART some two months after the drugs had

[408] Minister of Health . Accessed at: http://www.doh.gov.za/docs/sp/2007/sp1116.html . See Mafubelu D (2004).
[409] Speech by Dr Manto Tshabalala-Msimang, Minister of Health, at the Global World HIV & AIDS Alliance Conference, University of Zululand, 2 October 2007. Available at: http://www.doh.gov.za/docs/sp/2007/sp1002.html .
[410] Concerns on this point were expressed in both Mpumalanga and KwaZulu Natal provinces, with part of the explanation provided to AI for the delays in confirming appointments and filling posts being that the final authority resides with the provincial Head of Department of Health (HOD) and not at the operational level. In the former province the delays and apparent lack of sense of urgency in confirming appointments had been a concern frequently expressed to AI during visits to Mpumalanga province between 2001 and 2004. See Holdt VK, Murphy M (2007), pp.318-322 on the impact of centralization of decision-making on recruitments and budgets for hospitals in Gauteng Province.
[411] Schneider H et al (2006), p.18; Poggenpoel S, Claasen M (2004), p.16 who note that in 2003 52,574 posts were unfilled; Holdt V K, Murphy M (2007, pp. 331-332.
[412] Poggenpoel S, Claasen M (2004), pp.16-17, using data from the Health Systems Trust.
[413] NDoH (2006), chapter 4 p.76.
[414] SAMA Media Release: SAMA speaks out on Mpumalanga Hospital closure. 29 January 2008. Available at: http://www.samedical.org/. AI interview (by phone) with SAMA 12 February 2008. SPOs expressed concern to AI about the impact of these after-hours closures on availability of services for rape survivors.
[415] "Manto sets six-month deadline" (news24.Com, 11 February 2008). Accessed at: http://www.news24.com/News24/South_Africa/Politics/0,,2-7-12_2268692,00.html.

become available to the hospital. The clinical programme was being run by one doctor assisted by three other doctors who had other duties. The number on treatment represented less than one per cent of the estimated HIV infected population who clinically required ART in the areas which the hospital served.[416] Over three years later the number of patients on ART had risen to 3000, but the staffing had not proportionately increased. One of the international organizations assisting in the strengthening of the public health sector response to the HIV epidemic, Right to Care, however, began a support programme at the hospital in 2006, providing two additional doctors and other key staff such as counsellors and data capturers. There remained a waiting list of people needing to begin treatment.[417] Another rural hospital, which AI had visited in KwaZulu Natal province, had managed to increase its staff capacity from one to three physicians for the ART clinical programme. They had 1,700 registered patients in May 2007, with a 'scale-up' of more than 50 per month and a "minimal waiting list".[418] The provincial department of health has been exploring a number of measures in response to the difficulties in securing and retaining enough doctors, nurses and other key staff for comprehensive HIV services in remote area hospitals and clinics. These include seeking support from other government departments in the area of housing, education and transport to improve services in remote areas, reviewing salaries for nurses and bringing in more administration staff to protect the capacity of nursing staff to concentrate on clinical work with patients.[419]

The NSP recognized that the "unavailability of skilled personnel" represents a "major threat to the implementation of the NSP's interventions to provide prevention, treatment, care and support"[420] and must, as MSF noted, be confronted as an emergency. Civil society organizations monitoring the roll-out of ART and the implementation of the NSP have identified the need to address the health sector's human resources crisis as a key immediate priority.[421] In late 2007 some additional measures were announced by the Minister and also by several provincial departments of health, including increasing training provision for nurses and improving living conditions for rural-based health care staff.[422] These steps, however, may not be sufficient or rapid enough in their effects to overcome severe staff shortages in the public health sector. The WHO recommends a systematic analysis of human resource needs, in particular for effective delivery of HIV services.[423] The national government should also exercise its coordination and oversight responsibilities to call to account any provincial departments which may be failing to improve human resource management and decision-making on recruitments. Staffing shortages are a barrier to availability of health services and

[416] AI interview 20 August 2004.
[417] Interview with Right to Care (by phone), Johannesburg, 29 February 2008. http://www.righttocare.org/content/contact_us.htm
[418] Interview with hospital staff at Church of Scotland Hospital, Tugela Ferry, 8 May 2007.
[419] AI interview with staff at DoH KwaZulu Natal province (by phone), 11 February 2008.
[420] NSP (2007), p.147.
[421] Report of the 10th JCSMF meeting, Durban, 5 June 2007 (Accessed at: http://www.jcsmf.org.za/?q=node/112 .
[422] See above note 407. A bilateral arrangement between South Africa and Cuba for placement of Cuban doctors in rural hospitals has been long established. In July 2007 the MEC (Minister) for Health in KwaZulu Natal province announced measures to improve living conditions for staff in rural areas as well as strengthening schemes to facilitate placement of foreign doctors in provincial hospitals (IOL, 18 July 2007, 'KZN to get more foreign doctors'); similar drives were underway in the Eastern Cape (IOL, 17 July 2007, 'Eastern Cape Health Department on Recruitment Drive').
[423] WHO (2008), Recommendation 4.

thus can constitute a denial of the right to the highest attainable standard of health. The persistence of this barrier will have an obvious impact on the government's capacity to fulfil the country's health-related commitments made under the MDGs.[424]

Accreditation "bottlenecks"

"[M]any accredited service points are already functioning beyond capacity".
[NSP (2007)]

The consequence of staffing shortages in limiting access to HIV services has been compounded by delays in the accreditation of sufficient facilities to provide ART and related services, relative to the level of need. In turn staffing shortages have been a cause of delay within national and provincial departments of health in accrediting new facilities. Both of these factors have meant that for people diagnosed with AIDS in rural areas, gaining access to ART clinical programmes can be delayed for months after the diagnosis.[425] Where only hospital facilities have been accredited, then they may also have to travel excessive and costly distances to reach the nearest accredited facility.[426] In turn staff in those hospitals which are certified to provide treatment are overstretched. The grave effect of this situation of limited accessibility of services is to deny access to lifesaving medicines or to jeopardise the ability to adhere to treatment for many people marginalised by poverty. Rural women, who are disproportionately represented amongst the poor, are consequently particularly affected by these constraints. However some progress in addressing these consequences is beginning to be made through decentralisation of services and "task-shifting" within the health workforce.

The process of accrediting public health facilities to provide ART services is managed by both the National Department of Health (NDoH) and provincial departments of health. The NDoH's accreditation tool contains a long list of questions to be completed by the facility seeking accreditation, including information on the following: staffing, infrastructure, HIV–related patient intake, existing HIV-services currently available, laboratory and pharmacy capacity, access to medical specialist services, patient management systems and points of contact with volunteer support networks.[427] Some of these items are indicated as minimum requirements which have to be met for accreditation. In the revised 2006 version the presence on staff of a medical officer is not included as a minimum requirement. However a range of nursing staff is indicated as essential, along with capacity to access specialist medical services on or off-site. The NDoH has the responsibility to inspect and make final decisions on sites

[424] Bueno de Mesquita J, Gordon M (2005). The Africa Public Health Rights Alliance (APHRA) (2007) is campaigning for governments to implement the 2001 Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases. Abuja, Nigeria, 21 April 2001. Available at: http://www.uneca.org/ADF2000/Abuja%20Declaration.htm
and achieve the MDG targets. APHRA recommend that there should be at least three doctors, 10 nurses and one pharmacist per 1,000 of the population. South Africa falls below this level.

[425] Hassan F (2007) noted that at the time of writing approximately 30,000 people are on official waiting lists for ART at accredited facilities (p.104).

[426] See Odendal (2007) who notes that the delays due to staff shortages in the accreditation of an additional hospital in a rural area of the Eastern Cape Province meant that people needing or on ART had to travel up to 200 kilometres to access services from the accredited hospital. The delays in accreditation were also due to delays in the transfer of provincial government funds to the hospitals (pp.14, 23-24, 27).

[427] Comprehensive HIV and AIDS Care and Treatment for South Africa: Facility Accreditation Form (revised May 2006). Accessed at: http://www.doh.giv.za/docs/faform-f.html.

which have been identified and upgraded by the provincial departments of health. The budget is then sent to the province for the sites once accredited to provide ART. Initially the target was to certify at least one ART service point per each of the 53 health districts, then later further service points in sub-districts. By September 2006 nearly 70 per cent of sub-districts had at least one service point, according to the NDoH's project manager of the HIV and AIDS Treatment Plan. In February 2008 the number of accredited facilities in the public health sector had risen to 391, including several affiliated NGO-run health centres.[428]

The process has not always gone smoothly, however, with delays occurring in some provinces in finalising the accreditation of suitably equipped and staffed facilities, either due to lack of capacity or possibly a sense of urgency in the relevant departments of health. Some provinces had moved ahead quite fast, including KwaZulu Natal, which according to the NDoH had 77 accredited facilities by February 2008.[429] AI heard complaints, however, about serious delays in the accreditation process in Mpumalanga province, delays which were affecting the *availability* and *accessibility* of services, and thereby contributing to undermining the right of people living with HIV and AIDS to the highest attainable standard of health. According to NDoH data in September 2006, the province had 18 out of the 40 identified facilities with accreditation status. Five additional facilities had been accredited by February 2008. [430] This situation, according to information provided to AI by service-providing, advocacy and monitoring organizations, appeared to be a result of lack of a sense of urgency and strong provincial leadership, too few staff allocated to the task, as well as chronic delays in confirming staff appointments and the provision by the Public Works Department of basic equipment necessary for accreditation status. AI had been unable to obtain a response from the provincial DoH concerning its views on the accreditation process in the province by the time this report went to print.

Several international NGOs, including Absolute Return for Kids (ARK) and Right to Care, have with the agreement of departments of health responded to the problem of staffing shortages as an obstacle to accreditation. They have funded the provision of core staff teams and infrastructure needed by facilities trying to upgrade more swiftly to accreditation level or to expand capacity to increase the numbers of patients on ART.[431]

[428] NMF and MSF (2006), pp. 27-29, 41. At that time there were 273 accredited sites in the country according to NDoH (2006), Database of all ART facilities in South Africa, accessed on http://alp.org.za.dedi20a.your-server.co.za/images/upload/Oct06%20ART%20database.xls . By February 2008 the number of identified accredited facilities had risen to 391 (AI interview with NDoH, Pretoria (by phone), 25 February 2008). According to NDoH (2008), an updated list sent by the NDOH on 8 February 2008 to Deena Bosch, TAC, and forwarded to AI by the ALP, there were then 51 sub-districts still without accredited facilities.

[429] AI interview with NDoH, Pretoria (by phone), 25 February 2008. These facilities include four prisons and three NGO-run sites. The NDoH (2008) list shows 14 of the sub-districts still without accredited facilities. Information provided to AI in an interview with DoH KwaZulu Natal (by phone), 11 February 2008, indicated 80 accredited sites, which included 2 NGO-run clinics.

[430] NDoH (2006), Database of all ART facilities in South Africa, accessed on http://alp.org.za.dedi20a.your-server.co.za/images/upload/Oct06%20ART%20database.xls which shows Mpumalanga with 18 accredited facilities, all of them hospital sites. NDoH (2008) lists 23 accredited facilities and five sub-districts without accredited facilities. (AI interview with NDoH, Pretoria (by phone), 25 February 2008.)

[431] For instance ARK deploys "Swift Working Action Teams" consisting of a doctor, nurse, pharmacist and data-capturer and also provides computer equipment for data uptake. This type of intervention has assisted a number of facilities in Mpumalanga

Civil society organizations remain concerned that the accreditation process is too complex and creates unnecessary delays to the expansion of available and accessible facilities. In a submission in April 2007 to the South African Human Rights Commission's hearings on access to health care services, the AIDS Law Project, the National Education, Health and Allied Workers Union and the Treatment Action Campaign expressed concern that the national Ministry of Health was failing to address "bottlenecks" in the accreditation process which had the effect of denying "the provision of lifesaving medicines" to those not yet on treatment and overburdening those hospitals already accredited to provide ART. [432]

Increasing the availability and accessibility of accredited facilities

That the level of ART treatment need in South Africa vastly outstrips the availability of treatment centres and the capacity of their existing staff to provide services is evident from the gap between the actual numbers of people receiving ART compared with the number estimated to need the treatment. The NSP acknowledged the extent of this problem in commenting that "many accredited service points are already functioning beyond capacity".[433] In late 2006, during an exchange hosted by the Nelson Mandela Foundation and MSF between health care practitioners over models of ART delivery in "resource-limited settings", the project manager of the national ART roll-out, Dr David Kalombo, acknowledged that "most of our hospitals are overwhelmed, so we need to down-refer patients". Indeed, he continued, "we have revised the tool of accreditation, so that we have at least begun to down-refer stable patients to clinics." Additionally, there is a need to move towards "nurse-initiated treatment" at the level of Community Health Centres (CHCs) and Primary Health Care (PHC) facilities, "so that we can improve the uptake of patients."[434]

In a similar spirit, the NSP, which set as a target the provision of treatment, care and support to eighty per cent of people living with HIV by 2011, listed, as one of the "innovative ways" of achieving this target, a practice referred to as "task-shifting". This approach could allow, for instance, the deployment of trained primary health care nurses to initiate antiretroviral treatment.[435] The WHO, in its global recommendations and guidelines on task-shifting, described it as a process of moving specific tasks where appropriate to health workers with shorter training and fewer qualifications, in order to "make more efficient use of existing human resources and ease bottlenecks in service delivery".[436] This process, they

and elsewhere in South Africa to help speed up finalisation of their accreditation. (AI interview with ARK staff, Nelspruit, 3 May 2007; http://www.arkonline.org/projects/hiv_aids/index.html).

[432] ALP, NEHAWU, TAC (2007), para.3.3.

[433] NSP (2007), p.48.

[434] NMF and MSF (2006), pp. 29, 31). AI visited in May 2007 one CHC, in Inanda near Durban, which had begun providing ART in February 2007. The facility, which was very crowded with waiting patients, provides a range of services including a TB sub-clinic, maternity and labour ward, VCT, PMTCT counselling, testing and treatment, and operates on a 24-hour basis. The day and night staff do include doctors. AI visited in 2004 a private clinic, the ACTS Clinic near Masoyi in Mpumpalanga, which had been providing ART using funds from ARK, Right to Care and PEPFAR (see NMF and MSF (2006) pp.15-16 regarding this clinic). It was, in mid-2007, in the process of being accredited to provide ART and other HIV services as a public health sector clinic.

[435] NSP (2007), pp.59, 86, 147. In 2006 the Department of Health issued and then later withdrew instructions that ART should only be initiated by doctors (MSF (2007), p.13. The revised May 2006 facility accreditation form does not require the presence on staff of a medical officer (see http://www.doh.giv.za/docs/faform-f.html .

[436] WHO (2008), p.7.

recommend, should also be accompanied by the adoption of "competency based training that is needs driven", and a system of "supportive supervision and clinical mentoring" and referrals.[437]

The government's promotion after 1994 of primary health care, with over 1,300 new PHC facilities being built and several hundred upgraded, provides a basis for decentralising the provision of ART and related services. Although this approach is partly driven by the shortage of doctors, the shortage of nursing staff also remains a major challenge. Consequently task-shifting would have to require the mobilisation of "local communities" for the provision of services normally provided by nurses.[438] The WHO recognizes that "community health workers", including people living with HIV and AIDS, can make a significant contribution to decentralizing services to rural communities and should receive adequate wages or other commensurate incentives, for services to be sustainable.[439]

According to National Department of Health data from February 2008, KwaZulu Natal province had the largest number of accredited facilities providing ART (75), including four sites in prisons. Eighty per cent of the accredited health facilities were hospitals. Compared with earlier figures from 2006, the province has been gradually increasing the number of sites at CHC and PHC level as the capacity of hospitals became saturated.[440] All of the CHC sites have now been accredited, and the expansion into primary health care clinics includes two NGO-run facilities providing ART, now as part of the public health sector. One clinic, in a very remote area, Mkhanyakude, near the borders with Mozambique and Swaziland, is providing a 100 per cent decentralised service reachable by patients on foot, with the backup of a mobile doctor and pharmacy service.[441] In other provinces the proportion of non-hospital sites providing ART ranged from eight per cent (Mpumalanga) to nearly 55 per cent in the under-populated but large province of the Northern Cape. The Free State and the Western Cape provinces also showed significant trends towards non-hospital sites.[442]

Some studies of the implementation of ART clinical programmes at non-hospital sites have shown encouraging results. In some of these cases treatment had been initiated by doctors at a hospital, with ongoing care occurring at the PHC facility level; in other cases treatment was initiated by nurses at this level, with appropriate physician-led training and supervision. In the Free State, nurses at the accredited PHC facilities were providing treatment-preparation training for patients who had been initially assessed by a hospital-based doctor. After the training the patient would be referred back to the hospital for ART to be initiated. "Follow-up thereafter was based primarily at clinics, where nurses were responsible for issuing medication, clinical monitoring and adherence monitoring…"[443] Despite an initially insecure drug supply and greater patient numbers than had been planned for in

[437] WHO (2008), Recommendations 9 and 11.
[438] Schneider H et al (2007), p.295; Odendal L (2007), pp.20-22; MSF (2007), pp.2-3, 8-9, 19; NSP (2007), p.147. See discussion of the role of community workers in NMF and MSF (2006), pp.46-49, and MSF (2007).
[439] WHO (2008), Recommendations 14 and 20.
[440] NDoH (2008); NDoH (2006), Database of all ART facilities in South Africa, accessed on http://alp.org.za.dedi20a.your-server.co.za/images/upload/Oct06%20ART%20database.xls.
[441] Information provided to AI by DoH KwaZulu Natal, 11 February 2008.
[442] NDoH (2008).
[443] Stein J et al (2007), p.955.

relation to staffing levels, the nurses managed their substantially increased diagnostic and clinical roles effectively. The researchers reported that "staff expressed pride in the high adherence rates being…achieved", but found their counselling and support role the most challenging aspect of their work.[444]

In the Eastern Cape, the Lusikisiki PHC facility-based programme, supported until late 2006 by MSF, showed a faster enrolment of people into treatment at the twelve PHC facilities and better retention of patients in treatment, relative to the nearest district hospital programme. The PHC facilities and the hospital served a rural population of 150,000 people, 80 per cent of whom lived below the poverty line. By 2006 the combined efforts of the clinics and the hospital had resulted in 2,200 people being brought on to treatment, which, according to MSF, represented 95 per cent coverage of those estimated to need ART.[445] This primary health care clinic level programme also achieved a high proportion, at 81 per cent, of its patients remaining on treatment at or after 12 months. A similar rate has been achieved by some other non-hospital-based programmes in the Cape Town area, although their capacity to continue to initiate new patients on ART was reported to be diminishing.[446] Overall the removal of the barrier of transport costs for rural patients in Lusikisiki had helped increase access to HIV services and improve treatment adherence.[447]

A key feature of the Lusikisiki programme was the greater reliance on nurse-initiated treatment.[448] The area was reported to have only five doctors per 100,000 people, which is 14 times below the national average. The clinic nurses ran the ART programme, with training and regular mentoring and supervision by a mobile team of physicians. The nurses' increased diagnostic and clinical role was associated with an increased role for community health workers in, for instance, adherence monitoring, support groups and treatment preparedness for patients. This task-shifting was partly necessary due to the high vacancy rate in nursing posts, which in other parts of the Eastern Cape province has contributed to 'bottlenecks' in the provision of counselling, testing, assessment for and initiation of patients on ART and ongoing care.[449] An important additional benefit of task-shifting observed in the Lusikisiki programme was that it encouraged higher community participation and a decrease in stigma associated with the illness.[450]

[444] Stein J et (2007), pp.960-962
[445] Bedelu M et al (2007), pp.464, 467; MSF (2007), p.8; Ford N et al (2006), pp.17-22.
[446] These were a provincial DoH-run clinic in Gugulethu (90.3%) and three clinics in Khayelitsha (83.5%) run by the DOH and MSF (Rosen S et al (2007), pp.1694-1696 (Tables 1 and 2)). Regarding the latter three, MSF (2007) referred to them as reaching "saturation" point (p.9). ARK has reported a rate of 85 per cent of patients remaining in care and continuing to take their ARV treatment in relation to treatment centres, including primary health care facilities which they support (http://www.arkonline.org/projects/hiv_aids/index.html).
[447] A similarly encouraging outcome has been reported for another Eastern Cape initiative, at Madwaleni hospital where medical staff developed an HIV program closely tied to six satellite clinics in a deep rural area with significant physical access problems for the local population. Over a period of two years over 900 patients had been initiated on treatment. (Thom A (2007.)
[448] See discussion in NMF and MSF (2006) of the legal and regulatory framework which apparently does not prohibit nurses from undertaking treatment initiation and dispensing ARVs. The participants concluded that "in rural settings, where doctors are not available, nurses should be able to initiate patients on ART", but added that it "would be clinically advisable if severely ill patients that are very immuno-compromised are initiated by a doctor" (p.51).
[449] Odendal L (2007), pp.20-23.
[450] NMF and MSF (2006), pp.6-12; Bedelu M et al (2007), pp.465-467; Ford N et al (2006), pp.19, 20, 22. Lessons from Botswana, another high prevalence country, suggest that "better utilization of nurses has the potential to increase access to ART,

In May 2006, at a special summit of the Heads of State and Government of the African Union in Abuja, governments including South Africa recommitted themselves to combat HIV and AIDS, as well as tuberculosis and malaria. To this end they would, among other steps, "… ensure the integration of HIV/AIDS, TB and Malaria programmes into Poverty Reduction Strategies and Programmes; and thus ensure access to adequate nutrition and food security, other social protection measures as well as treatment, care and support." In addition they would work to "strengthen health systems…for scaling up and accelerating Universal Access to prevention, treatment, care and support for HIV/AIDS, TB and Malaria.[451]

These broad commitments are reflected in the NSP, which itself reflected a consensus between government, civil society organizations, health care providers, people living with HIV and other concerned organizations on how to overcome barriers to prevention, treatment and care and universal access. The NSP affirmed "tackling inequality and poverty" as one of the guiding principles necessary for the progressive realization of the right to access to health services. It envisages that a range of anti-poverty interventions would contribute over the five-year period of the plan to the fulfilment of that right. The NSP's targets include increasing to 70 per cent the proportion of adults starting ART in non-hospital settings, with a similar proportion either initiated or managed on treatment by nurses.[452]

As indicated in the preceding pages of this report, there is evidence that women who are living with HIV in circumstances of poverty and unemployment in rural areas, face continuous challenges in maintaining regular access to health services. These services are not physically and economically accessible to everyone without discrimination. Their availability is limited also by staffing shortages and bottlenecks in the accreditation process. The lack of secure access to adequate food daily also remains as a barrier to the women's realization of their right to health. It is only with considerable difficulty, as well as great determination, that the women whom AI interviewed were able to manage their treatment and try to improve their health. Government social grants did assist the ability of some of the women to cope with their health needs and family responsibilities. However the restricted criteria for eligibility for disability grants were a source of anxiety for them. The official acceptance, in the NSP, of the need to decentralise HIV services, in conjunction with the development of task-shifting, should contribute in the longer-term to the women's increased access to health services and the realization of their right to health.

In fulfilment of the country's obligations under international human rights standards and as progress towards accomplishing the targets set in the NSP, the government should ensure that:

reduce congestion at centralized ART centres, reduce unnecessary travel by patients and allow for localized provision of support for adherence and education" (Miles K et al. (2007), WHO (2008), p.44). See also the benefits reported by ARK from its community-based 'patient advocate' scheme which has encouraged people to seek and adhere to treatment (http://www.arkonline.org/projects/hiv_aids/index.html) .

[451] Special Summit of African Union on HIV/AIDS, Tuberculosis and Malaria, Abuja, Nigeria, 2-4 May 2006, Sp/Assembly/ATM/2(1) (available at: http://www.africa-union.org/root/au/conferences/past/2006/may/summit/doc/en/ABUJA_CALL.pdf); see also Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases. Abuja, Nigeria, 21 April 2001. Available at: http://www.uneca.org/ADF2000/Abuja%20Declaration.htm

[452] NSP (2007), pp.55, 85-86.

- the barrier of transport costs is addressed as a matter of urgency by government at national, provincial and municipal levels;
- information about state-funded nutritional and meal supplements is fully dispersed to all health care facilities and social welfare offices and barriers to access to these services are addressed;
- all possible measures are taken, including with international support, to improve the availability of health services by increasing health sector staffing, including by accelerating recruitment processes and the filling of vacancies, the strengthening of training programmes, and encouraging the retention of staff by improving their working conditions and their remuneration (especially in under-served areas);[453]
- support continues for the expansion of ART clinical programmes at non-hospital sites in rural areas, including by devolving clinical decision making on HIV care down to the most effective level of competent operational management, with the necessary capacity-building and supervision for nurses and community outreach workers;
- the remaining obstacles at national and provincial levels to the completion of the accreditation process are addressed to ensure universal access to ART and other HIV services; and
- these steps are taken within agreed human rights and policy frameworks, with appropriate monitoring, demonstrable accountability and regular evaluation of the services delivered.

National and provincial governments should ensure that budget allocations for HIV and AIDS programmes are targeted to include addressing effectively these barriers to the realization of the right to the highest attainable standard of health for rural women. At the conclusion of the declaration made at the 2006 AU Special Summit in Abuja, the Heads of State and Government called on "[d]evelopment partners to continue to work closely with Member States, the AU Commission and the [Regional Economic Communities] to assure long term, predictable financing commensurate with the burden of these diseases [of HIV/AIDS, TB and Malaria] and to provide financial and technical support to [their] efforts in a coordinated, efficient and country and AU led manner".[454] Any shortfall in state budget could be met by increased efforts to mobilise international assistance and cooperation, while at the same time undertaking measures to improve capacity and accountability within departments responsible for delivering health care and related services. States have the primary obligation to ensure the respect, protection and progressive fulfilment of human rights within their borders. However, international standards recognizing the right to health

[453] MSF (2007) see the role of donors, as well as governments, as critical to resolving the shortage of health care workers in the context of the AIDS pandemic in Southern Africa.

[454] Special Summit of African Union on HIV/AIDS, Tuberculosis and Malaria, Abuja, Nigeria, 2-4 May 2006, Sp/Assembly/ATM/2(1) (http://www.africa-union.org/root/au/conferences/past/2006/may/summit/doc/en/ABUJA_CALL.pdf. See APHRA (2007), p.2 (table showing health expenditure for countries with highest overall TB prevalence in Africa, which notes that the percentage of "external resources for health as a % of expenditure on health" in South Africa is 0.5%).

also recognize the role of international cooperation and assistance (including financial and technical) in realizing or undermining the right.

6. Conclusion

The period of democracy in South Africa since 1994 has coincided with the most intense increase in the prevalence of HIV and the feminisation of the epidemic. The legacies of the apartheid period – the deliberate underdevelopment of black residential communities and rural "homeland" areas, the lack of effective policing apart from reasons of political repression, and the racially skewed delivery of health and other social services and access to education – still pose major challenges to a government under pressure to respond more immediately, effectively and compassionately to the problems of persistent poverty, high unemployment, preventable diseases and the consequences of violent crime. Although the formal, legal status of women and the level of their participation in political life have improved enormously since 1994, women, particularly rural women living with HIV who are the focus of this report, are disproportionately affected by poverty and unemployment. They continue to experience discriminatory attitudes and practices, particularly from male partners, and to live in a general environment of high levels of sexual and other forms of gender-based violence.

AI concluded from the research conducted for this report that there is evidence indicating that the realization of the women's right to the highest attainable standard of health is impeded by:

- the lack of secure income which affected their ability to access health services and adequate food, although the state provision of various kinds of social grants mitigated the worst effects for some women;
- the lack of affordable and reliable transport enabling them to reach HIV-related health services urgently or for necessary monitoring, treatment and care;
- the still limited availability of comprehensive HIV services including ART in rural areas due to severe staff shortages, some which appeared to be caused by the lack of due diligence on the part of department of health officials responsible for recruitments and planning, particularly in Mpumalanga province, but also by the competitive pressures from the private sector and foreign governments;
- the still limited accessibility and availability of comprehensive HIV services including ART in rural areas due to blockages in the accreditation process, particularly in Mpumalanga province, for certifying sufficient, decentralised facilities to offer these services, although positive trends are emerging in some provinces in this regard;
- the impact of sexual and other forms of gender-based violence on the women, who had been exposed to the risk of HIV infection through coercive unprotected sex and/or from the longer-term consequences of living in abusive relationships;
- the impact of other forms of discrimination against women and social stigma attached to HIV and AIDS which impeded their ability to make the best decisions for their

health, including being able to refuse unprotected sex and undergo HIV testing without risks of verbal abuse, violence or threats of violence and abandonment;

- the impact of the obstacles to their access to legal remedies due to still inconsistent practices, poor training and under-resourcing in the police response to crimes of violence against women in rural areas; and
- the impact of the lack of information on or actual shortages of shelters for women experiencing domestic violence.

In view of these findings and South Africa's human rights obligations, AI has made a number of recommendations as outlined in the following pages.

7. Recommendations to the Government of South Africa

The Government of South Africa, in its response to the HIV epidemic, has obligations under both national law and international human rights law to eliminate all forms of discrimination, including on the grounds of gender, sexuality or economic status, in the realization of the right to health. It also has obligations to promote, protect and fulfil women's right to equality, their sexual and reproductive rights and right to freedom from all forms of violence and abuse. The following recommendations are made in the context of these human rights obligations, as well as commitments made in intergovernmental human rights declarations and undertaken through the NSP process. The recommendations seek to address some of the urgent needs confronting rural South African women living with HIV and experiencing or at risk of violations of their internationally recognized human rights.

A: Recommendations aimed at the elimination of discrimination in the realization of the right to health

Address economic and social inequalities affecting women

AI recommends:

- that the government intensifies efforts to address women's wider social and economic inequalities which act as barriers to effective prevention, treatment and care for HIV and AIDS;
- that an increased monitoring and mobilising role by a strengthened Commission for Gender Equality, in conjunction with the parliamentary Joint Monitoring Committee on Improvement of Quality of Life and Status of Women and other mechanisms could assist in identifying gender gaps and pressing departments of state at national and provincial levels to deliver sustained and effective interventions.

Ensure transport costs and distances in rural areas do not impede access to health services

AI recommends:

- that the barrier of transport costs be addressed as a matter of urgency by government at national, provincial and municipal levels, whether through some system of subsidized or free transport, or patient grants to cover transport costs or other measures which do not have the effect of stigmatising those who may use such systems or do not impact negatively on right to access to health services of others;
- that in the context of the NSP goals and objectives and the review of existing state social grants, that a 'chronic illness' grant be considered to improve the ability of people living with HIV and AIDS in circumstances of poverty to maintain their access to health services and adhere to treatment.

Increase accessibility and availability of ART services in rural areas

AI recommends:

- that support continues for the expansion of ART clinical programmes at non-hospital sites in rural areas, including by devolving clinical decision making on HIV treatment and care down to the most effective level of competent operational management, with the necessary capacity-building and supervision for nurses and community health workers;
- that all possible measures are taken to improve the availability of health services by increasing health sector staffing, including by accelerating recruitment processes and the filling of vacancies, the strengthening of training programmes, and encouraging the retention of staff especially in under-served areas by improving their working conditions and their remuneration;
- that "designated centres" for the provision of post-exposure prophylaxis (PEP) services to women at risk of HIV infection as a result of rape should also be fully accessible without discrimination resulting from the survivor's lack of economic resources or transport;
- that PEP services should continue to be part of comprehensive, post-sexual assault health and medico-legal services of good quality and accessible to rape survivors without discrimination.

Ensure access to adequate food

AI recommends:

- that to assist people living with AIDS, including women who are disproportionately affected by poverty and unemployment, to adhere to ARV treatment and maintain their health, access to information about state-funded nutritional and meal

supplements should be improved and barriers to access to these services should be removed.

B: Recommendations aimed at combating violence and other forms of discrimination against women

Prevent violence against women

AI recommends:

- that government departments, the police and municipal authorities ensure funding is allocated for the development and implementation of plans to improve women's physical security by identifying and addressing dangers to their safety in the physical environment and transport systems. These plans should be developed in cooperation with the communities affected, local businesses, non-governmental service providing organizations and other elements in civil society;
- that government ensures budget for and police management gives greater priority to increasing the level of police personnel, vehicles and equipment for rural-based police stations. Priority attention should be given to those police stations which SAPS identified in 2007 as responsible for 40 per cent of the reports of rape and other "socially motivated contact crimes";
- that all branches and members of the police are trained fully on their obligations to protect women's rights as guaranteed in human rights treaties to which South Africa is party and the Constitution, and implemented through national laws such as the Domestic Violence Act and the Criminal Law (Sexual and Related Matters) Amendment Act (SO Act).

Improve women's access to civil and criminal remedies in cases of violence against women

AI recommends:

- that national guidelines and instructions for the effective implementation of the new SO Act by police and the prosecution services be developed and disseminated as a matter of urgency;
- that the Act be kept under review to ensure it can provide an improved instrument for prosecuting crimes of sexual violence, particularly in view of concerns expressed that the final form of the law had eroded the protections afforded rape complainants and other vulnerable witnesses contained in the initial draft law;
- that the impact of the decentralisation of the Family Violence, Child Protection and Sexual Offences Unit (FCS) be kept under review and the decision reversed should it be confirmed that the quality of investigative and other FCS services has deteriorated;

- that the government accelerates the implementation of the 'victim empowerment' programme to ensure that all police stations have appropriate interviewing facilities for victims of sexual violence and women experiencing domestic violence;
- that the police, social welfare and health services improve women's access to information on and the availability of shelters.

Increase men's awareness of and respect for women's rights

AI recommends:

- that HIV prevention programmes target and seek to change patterns of male sexual risk taking, condom refusal and violent or other abusive behaviour towards women when they assert their sexual and reproductive rights;
- that government and other political leaders condemn unambiguously such abuses of women's rights and actively use media campaigns and awareness-raising measures for promoting men's respect for women's right to equality and sexual autonomy.

Encourage assessment by health personnel of risks to women

AI recommends:

- that the government response to violence against women should include raising the awareness of and capacity for screening by health service staff and VCT counsellors, for the risks of violence and other manifestations of inequality and discrimination faced by women living with HIV;
- that additional and periodic training for health care staff and VCT counsellors be provided, along with strengthened systems for support, referral and follow-up for women at risk of abuses, in co-operation with NGO-service providing organizations, community health workers and home-based carers.

Assist women in disclosing their HIV status safely

AI recommends:

- that in the context of far greater numbers of women testing than men, the department of health and other relevant departments should pay particular and urgent attention to the capacity of HIV testing services to anticipate and address possible adverse consequences for women when they disclose their test result to male partners and families;
- that during post-test counselling women should be provided with information on and means to access support through social welfare agencies, NGO-service providing organizations, community health workers and home-based carers, as needed, to assist

them through the process of disclosure to their male partners, as well as other family members;

- that in scaling up HIV testing to achieve the NSP targets, greater efforts are made to encourage men to get tested, including with their partners;
- that every effort is made to ensure that all testing for HIV is conducted with informed consent of the person to be tested, that the person is adequately counselled on the implications of an HIV-infected test result and that all test results are confidential.

Recommendations to Second Governments and donor institutions

While states have the primary obligation to ensure the respect, protection and progressive fulfilment of human rights within their borders, international standards recognizing the right to health, for example, also recognize the role of international cooperation and assistance (including financial and technical) in realizing the right. In view of the extraordinary disease burden posed by the scale of the HIV epidemic in South Africa and the continuing impact of gender inequalities, poverty and shortages of health care staff in the realization of the right to health, AI recommends that second governments and donor institutions establish or increase existing support for programmes intended to address these barriers.

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'I am at the lowest end of all'

Rural women living with HIV face human rights abuses in South Africa

South Africa is continuing to experience a severe HIV epidemic. Five and a half million South Africans are HIV-infected, the largest number in any country in the world. Over half of them are women.

This report is based on interviews with rural women, the majority of them living with HIV. They describe their experiences of oppression in their relationships with male partners and within the wider community because of their gender, HIV status and economic marginalization.

The scale of violence against women, including sexual violence, has remained persistently high in South Africa. Despite measures to reform the justice and policing response, the women's lives continued to be scarred by violence and fear of further violence with serious consequences for their physical and mental health.

Their ability to maintain their health was undermined by the continuing lack of sufficient, comprehensive HIV health services in rural areas and the cost of transport.

Despite gradual improvements in the state's response to the HIV epidemic, and the recent adoption of a widely welcomed five-year plan, rural women still face enormous barriers in realizing their right to health.

This report makes a number of specific recommendations to the national and provincial authorities, and to donor countries and institutions supporting initiatives in South Africa. These recommendations are aimed at addressing the impact of discrimination, violence and poverty on rural women living with HIV.

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