Chapter 11

Gender and health
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11.1 Introducing gender and health in South Africa

Men and women are different. And the difference, whether real or perceived, matters. Simply put, the health status of people is often affected by whether you are male or female, as well as the gender stereotypes that are prevalent in any particular society.

This chapter explains why human rights, gender and health are important concepts for all South Africans to understand. After beginning with an exploration of certain key concepts and terms, it considers the factors that bring about good health in both men and women, while describing what gender barriers prevent the different sexes from accessing appropriate health care services.

The chapter then briefly discusses reproductive and sexual health rights, and examines the national and international frameworks that set out the content – and the mechanisms for the enforcement – of these rights.

The two final parts of the chapter focus on specific health issues that relate to women and to men, and set out the policies and laws that regulate these issues in the public and private sector.

Understanding key terms and concepts

The terms “sex” and “gender” are often used to describe the differences between men and women.

- **Sex** refers to the physical or biological differences between men and women, eg men have penises and women have vaginas.

- **Gender** refers to the ideas that people have of what it means socially to be a boy or girl, or a man or woman.

*Gender relations* describe the norms, roles, values, attitudes and expectations that guide how women and men will behave and be treated in any given society. Gender relations are not fixed - rather they vary from society to society and from time period to time period, because they represent opinions and social constructs rather than biological facts.

Gender relations are often *heterosexist*. This means:

- Women are expected to be sexually attracted to men, and men to women.

- Stigma and discrimination attach to people with different sexual orientations from heterosexuals, eg gay men, lesbians and bisexuals.

While this chapter recognises the health needs of both men and women, its focus is on women, who have historically borne the brunt of unfair discrimination on
the basis of gender. The political and economic disempowerment of women over centuries affects the ability of women – even today – to achieve good health. In this regard, it is important to note that it is not only access to health care services that is necessary for improving one’s health status. Other rights are equally important, such as the right to work, the right to an education and the right of political participation. The enjoyment of these rights, which have been denied to women in the past and continue to be denied in some societies, is often a prerequisite for the enjoyment of health care rights.

**Gender roles**

Gender roles are the specific duties and responsibilities that women and men are ordinarily required to perform in society. These have an important function to play in determining the nature of gender relations.

In many societies, including South Africa, women are expected to stay at home take care of children, the elderly and the frail, as well as cook and clean. Men, on the other hand, are expected to earn money and be responsible for the financial well-being of their families. This means that in these societies, women may have fewer educational opportunities and men may have less opportunity to spend time with their children.

In South Africa, many traditional family structures were destroyed by various aspects of apartheid, such as the migrant labour system and forced removals. The AIDS epidemic has further exacerbated the effects of social dislocation and has increased, for example, single parenthood and overcrowded living conditions.

Societies give different values and status to these gender roles. In most societies, the types of activities that are carried out by men are valued more than those done by women. Women’s work, like men’s work, is critical to the functioning of society, but is seldom adequately valued.

This is because women’s work tends to take place inside the household and is often not seen by people outside the home. It is usually taken for granted and done without pay. Some men also work in the home, but tend to do only certain kinds of work.

**Example: Common domestic roles for men**

Many men take care of the garden, change light bulbs or fix the roof, but do not feel comfortable feeding the baby, cleaning the house or cooking the food, as these are often seen to be “women’s work”.
Outside the home, men tend to make up more of the highly paid professions. “Men’s work” is linked to active rather than passive roles. For example, there are more male security guards than male secretaries.

These ideas about how men and women should behave determine power relations in societies and communities. Gender roles also have an impact on men’s and women’s health, such as what type of medical conditions men and women are likely to have, and how, when and if they seek medical assistance.

The Constitution and gender equality

Through the Constitution and the Bill of Rights, all South Africans now have the right to gender equality and access to health care services. A core component in South Africa’s aspiration towards gender equality is ensuring that women are able to access safe, adequate and gender-sensitive health care services.

If women are healthy and empowered to make decisions about their bodies, they will be more economically empowered and able to gain more social power. Thus, appropriate health care and gender equality is strongly related, just as gender inequality is linked to disease and neglect.

While there is constitutional recognition of this right, the process of making this right felt in real terms is a slow one. It requires redressing laws, policies and practices that do not respect gender equality. This is the easy part. The more difficult aspect of pursuing gender equality is to reach into the private sphere – the home and relationships – to change attitudes and mindsets. The law is an inadequate tool for achieving this second goal. But through proper protection of all human rights, men and women will be better able to shift societal understanding of gender roles.

11.2 Gender and good health

The World Health Organisation (WHO) defines good health as “a state of complete physical, mental and spiritual well-being and not merely the absence of disease”. For men and women, what constitutes good health or well-being may mean different things and may require diverse services from the health care system. Primary health care, like all other levels of health care services, should be adapted to meet the needs of the different sexes.
The different health needs of men and women

Different health needs may stem from the following:

- **Biological and anatomical differences:** the type of interventions that may be necessary for reproductive health, for example, will differ between men and women. Biological differences also mean that men and women are susceptible to different illnesses – for example prostate cancer in the case of men and cervical cancer in the case of women.

- **Social and cultural determinants:** social beliefs and practices and violent attitudes may bear directly on one's health. For example, improperly performed male circumcision causes health risks for boys and young men. A different example is that of gender-based violence. While men are raped (currently recognised in our law as indecent assault, with rape being restricted to non-consensual vaginal intercourse), most people who are raped are women. At least 100 000 rapes were reported in South Africa in 2003/4. A person who is raped is in immediate need of testing and treatment for sexually transmitted illnesses, including HIV, treatment for physical injury as well as mental injury. In the case of women specifically, access to services for the termination of pregnancy may also be required.

One statistical example of how gender roles impact differently on the health of men and women is data recorded on the nature and cause of death for men and women.

**Example: Causes of death**

As early as 2000, HIV/AIDS was already the main cause of premature death amongst both men and women. Nevertheless, the epidemic had – and continues to have – a disproportionate impact on women: 46% of premature deaths amongst women were attributed to HIV/AIDS; whereas 32.9% of premature deaths amongst men were due to HIV/AIDS.

Homicide or violence was the second highest cause of death for men (11.6% of all deaths), in contrast to 2.7% of all deaths for women (ranked as the seventh highest cause of death).

In 2006, a report published by Statistics South Africa showed that while there were 23 360 deaths of men between the ages of 25-29, there were 41 530 female deaths.
What are the health needs of women?

Women have a number of health needs that demand serious investment of resources – both financial and human – in the health system. In particular, women need to access a range of health and complementary psychosocial services that will realise their reproductive and sexual rights. In addition, many women’s specific needs are often inextricably linked to their social status.

Examples: The status of women

Women’s subordinate status in society means that they are often in violent relationships that are both physically and emotionally abusive.
Therefore, women may need to be hospitalised more often for injuries linked to domestic violence than men.

- Women are twice as likely as men to suffer from depression – largely because of poor self-esteem that is linked to many social and economic factors. These include the fact that women are considered to be less important than men in their families and communities, and are more likely to be victims of intimate violence than men.

Section 27(2) of the Constitution places an obligation on government to take all reasonable measures, within its available resources, to progressively realise people's rights of access to health care services. In the context of women's health and gender needs, this means, for example, that government should put structures and processes into place to ensure that health care services are accessible and appropriate for women, taking their position in society into account.

Example: Providing for the needs of women

Women should:

- Be able to access information on and be able to choose from a range of methods to control their fertility (eg contraception, sterilisation and abortion).
- Have access to screening for different cancers.
- Be able to decide how, when and with whom to have sexual relations.
- Be able to protect themselves against sexually transmitted infections (STIs), including HIV.
- Be protected from harmful traditional practices such as female genital mutilation and virginity testing.

Accurate and accessible information on nutrition for pregnant women, safe infant feeding practices and services to reduce the risk of mother-to-child-transmission (MTCT) of HIV should be available to all women.

Researchers have argued that mental health in South Africa is an underemphasised and underfinanced area of care. According to their findings, women should be able to access psychosocial counselling and support as a result of being much more affected by:

- The trauma of domestic and sexual violence.
- The stresses of taking care of children and the frail.
- The lack of control over important aspects of their lives.
What are the health needs of men?

The life circumstances of men result in different types of vulnerabilities. Men are more likely to work in dangerous environments like mines, factories and the military that may make them more prone to, for example, respiratory diseases or a loss of limbs or life.

The excessive use of alcohol by many men is often condoned as a sign of manhood. It is therefore not surprising that men are almost three times more likely than women to be dependent on alcohol. This means that the health system needs to provide more support to men on this issue than women.

There are a number of medical conditions that men are more likely to have than women. Men should ideally have regular medical examinations for heart disease, cholesterol and prostate cancer, especially if these are conditions that run in their family.

Some men working in dangerous circumstances or with hazardous materials, such as in mines and factories, should be regularly screened for occupational-related illnesses such as asbestosis and silicosis.

Young men should be in a position to choose whether they would like to undergo traditional or cultural practices such as initiation and circumcision. When done, these procedures should be carried out by trained and responsible individuals in hygienic and dignified circumstances.

For more on initiation and male circumcision, see Chapter 7.

What are the gender barriers to accessing adequate health care services?

In South Africa, various barriers exist that may hinder both women and men from accessing adequate health care. In general, these include economic barriers (inability to afford health care services), social barriers (such as stigma that attaches to certain illnesses such as HIV/AIDS and deters people from accessing health services) and health system barriers (such as a shortage of health services and health care workers across the country). These barriers are often reinforced by sex and gender. Where some (or all) of these barriers do not exist, as may be the case with many middle class women, gender and sex may not play such a fundamental role in determining questions of health care access.

Key Points: Meeting different needs

In working towards better health care provision, activists should challenge gender inequality and ensure that the different and complex needs of men
and women are met. Educational programmes should focus on empowering girls and boys to value as well as to take responsibility for their health from a young age, and to respect each other.

In this process, disseminating accurate and accessible information is a vital part of what is needed to build an equitable health system. Equally important is to ensure that people are in a position to make and implement healthy lifestyle choices.

**Specific gender barriers to women accessing adequate health care services**

**LIMITED CONTROL OVER SEX AND REPRODUCTION**

A substantial number of women in South Africa have little control over decisions relating to sex and reproduction. Many women’s male partners or male relatives decide what is best for them and for their lives, and make fundamental decisions for them on:

- When they should get married.
- When and with whom they can have sex.
- When and how many children to have.

Many women’s mobility and interaction with other people is determined by their male partners. Some women cannot even go to the clinic or hospital without first asking permission from their husband or boyfriend. This has a powerful impact on their health-seeking behaviour, including the type of medical care they seek.

**Example: Going for an HIV test**

- A woman who wants to know her HIV status may be expected first to ask permission from her male partner to go for an HIV test. This could make her potentially vulnerable to violence and accusations of being unfaithful to her partner, while he may forbid her to take the test.
- Having to tell her partner about testing also disrespects her right to confidentiality. If she gets permission from her partner for the test, she will probably be expected to tell him the results. This could lead to violence or abandonment if she tests HIV positive.
TIME FACTORS

Many women face time-consuming child-rearing and domestic responsibilities in addition to formal economic activities to maintain their family. As a result, many women do not have the time to seek medical assistance, go for regular medical check-ups or collect medicines prescribed to them. However, men are more likely to be formally employed and therefore less likely to have the time to seek health care. When both men and women are employed, women are less likely to access health care services in the workplace, which have traditionally been offered in male-dominated industries like mining.

LACK OF SUPPORT FROM SOME HEALTH CARE WORKERS

Gender-insensitive health care workers may not alert women to their reproductive and sexual rights and may even discourage women from seeking specific treatments or medication. Consider the issue of abortion. Health care workers who are ideologically opposed to a termination of pregnancy may not inform pregnant women that they have a choice in terminating their pregnancy, even though they have a legal and ethical duty to do this.

Studies have shown how the disapproving or judgmental attitudes of health care workers create barriers for girls and young women in obtaining information about sex, or in accessing reproductive health services like contraception and termination of pregnancy.

CASE STUDY: VIRGINITY TESTING

A 2001 report by Human Rights Watch revealed that virginity tests were being conducted at some schools in KwaZulu-Natal. It reported that in the Osizweni district, local teachers administered tests to as many as 3,000 children and awarded certificates to students who passed. There were accounts of children as young as six being pressured to take part in virginity tests.

Virginity testing cannot be seen as an HIV/AIDS prevention measure. It also infringes on a girl child’s right to privacy, is gender discrimination, and violates the right to bodily integrity.


See Chapter 9 for an explanation of how the 2005 Children’s Act prohibits virginity testing of women under 16.
Specific gender barriers to men accessing adequate health care services

A number of harmful gender stereotypes and popular ideas about masculinity influence men’s health-seeking behaviour. If societies socialise boys and men into believing that being ill, reacting to pain or seeking medical help for ailments are signs of weakness and being unmanly, then men are less likely to make adequate use of health care services.

Engendered ideas about masculinity place significant value on men’s sexual prowess, virility and sexual abandon. Men who experience sexual problems or who want to obtain condoms may be too embarrassed to discuss these issues with health care workers or seek help from them. It is important for educators and activists to challenge the harmful stereotypes associated with masculinity and to encourage men to go for help at health care services.

Example: Vasectomy

- A vasectomy is male sterilisation. It is a small and very safe operation that stops a man from releasing sperm into his semen.
- The operation consists of cutting the vas deferens (the tube that carries the sperm from the testicles to the urethra before the man ejaculates) and tying up both ends of the vas deferens so that the sperm cannot join the semen. It is done under local anaesthetic and takes only a few minutes.
- Vasectomy does not affect a man’s sex drive. Ejaculation and orgasm will be the same, and the semen is still produced as before. The only difference is that there are no sperm in the semen.

Source: Adapted from Men’s Sexual Health Matters, page 36

The social weight attached to men’s virility has had a direct impact on the number of vasectomies demanded and performed in South Africa:

- Male sterilisation is a simpler and cheaper technique than female sterilisation, yet many more women are sterilised as a means of contraception than men are.
- Vasectomy services are almost non-existent in the public sector.

Points to remember: Access to sterilisation

- Both male and female contraception should be promoted.
- Men and women should be able to access sterilisation services if they choose to be sterilised.
- Vasectomy services should therefore be expanded and offered as an option to men.
11.3 Reproductive and sexual health rights

The content of reproductive and sexual health rights

At the International Conference on Population and Development in Cairo in 1994, reproductive health was defined as:

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

For women, reproductive health services include preventative services, management of STIs and HIV/AIDS, infertility, abortion, and cancers of the reproductive system, contraceptive services, antenatal care, safe delivery and post-natal care. All these reproductive health services are based on the principle of upholding women’s rights to dignity, bodily integrity and bodily autonomy. Important as these issues are, it is important to remember that women’s health needs are not restricted to reproductive needs.

Sexual rights of men and women

Women and men are also entitled to sexual rights, which, although closely linked to reproductive rights, are quite distinct. Sexual health forms a vital component of general health, whereas poor sexual health can threaten general health in various ways.

All men and women are entitled to:

- Control over their own bodies.
- Only have sex when, with whom and how they want to.
- Live out their sexual orientation.
- Not to be forced to have sex through the use of violence or coercion.
- Have sexual enjoyment.
- Be protected from diseases such as HIV and STIs.
- Exercise the responsibilities that go with sexual rights.

The realisation of sexual and reproductive rights is essential to the full well-being of men and women.
Constitutional rights

Reproductive and sexual health rights are expressly recognised in the Bill of Rights of the Constitution.

Section 27(1)(a) of the Constitution says:

“Everyone has the right to have access to health care services, including reproductive health care.”

Section 12(2) says:

“Everybody has the right to physical and bodily integrity, which includes the right –

a) to make decisions concerning reproduction;

b) to security in and control over their body; and

c) not to be subjected to medical or scientific experiments without their informed consent.”

These rights should be read together with the equality provisions in section 9 of the Constitution. This provision guarantees that no-one is allowed to discriminate unfairly against another person on grounds such as gender, sex, sexual orientation, pregnancy or marital status.

Reproductive health rights

In dealing with rights to reproductive health care and choice, and with gender equality, the Constitution recognises that women’s access to reproductive health services has been limited in the past. Central to the Constitution is the recognition of the importance of women being given a choice and the means to exercise a choice on all issues concerning their bodies. Such an approach aims to assist women to live out their fundamental human rights to dignity, autonomy and freedom, as well as help bring about gender equality.

Examples: Laws implementing women’s rights

- The Choice on Termination of Pregnancy Act 92 of 1996 puts practical steps into place that enable women to choose whether they carry their pregnancy to full term, or terminate it.
- Section 2(c)(iv) of the National Health Act 61 of 2003 recognises specifically that the rights of vulnerable groups, which include women, should be protected, respected, promoted and fulfilled.
International law

These rights are in keeping with various international covenants and guidelines on people’s and women’s health and well being, such as:

- The Beijing Declaration and Platform for Action.
- The Declaration on the Elimination of Violence against Women.
- The International Covenant on Economic, Social and Cultural Rights (ICESCR).

For more on international law, see Chapter 5.

These international declarations express the fundamental rights of women and the obligations of States in realising these rights. They provide strategies and propose interventions that Governments and civil society can use in order to promote and ensure gender equality.

Laws and policies that are directly related to reproductive and sexual health rights

Cancer of reproductive organs

CERVICAL CANCER

Cervical cancer (cancer of the cervix) is a very common form of cancer amongst women in South Africa. The cervix is the mouth of the womb and connects the womb with the vagina. In almost all cases, cervical cancer is caused by the human papilloma virus (HPV). HPV is a common sexually transmitted virus that usually goes away by itself – most people never even know they have it. In some cases, however, HPV does not go away. Instead, it causes abnormal, or pre-cancerous, cells to form. If these abnormal cells are not found and treated, they may become cancerous.

The National Cancer Registry, released in November 2003, shows that:

- Cervical cancer is the most common cancer among South African women between the ages of 15 and 29 years.
- Young black women are the most vulnerable to this disease.

A procedure called a Papanicolaou smear (“pap smear”) can detect whether a woman runs the danger of cervical cancer, and has in theory been part of a free package of care offered to South African women since 1996. Cancerous or pre-cancerous cells, if detected early, can be removed before they develop into full-blown cancer.
The Department of Health (DoH) National Guideline on Cervical Cancer Screening Programme creates a national framework for cervical cancer, and states that all asymptomatic women in South Africa should have at least 3 free pap smears in their lifetime, starting when they are 30. This policy does not take into account the evidence from research indicating the higher risk for women between 15-29 years. A more logical and responsive policy should provide access to screening services for sexually active women in this age group. Waiting until women turn 30 will be too late for the majority of those at risk.

While pap smears are not part of the prescribed minimum benefits (PMBs), meaning that medical schemes are not obliged – by law – to cover the cost of their provision, many schemes in fact cover the costs of these tests as part of their benefits to members.

Women who are able to afford private medical care through medical scheme membership are entitled to medical and surgical management of cervical cancer. This includes radiation therapy and chemotherapy, as these are listed in the PMBs.

However, one can also access health care services for cervical cancer in the public sector. In fact, because medical schemes have limits to their benefits, private sector patients may be required to access appropriate health care in the public sector when their benefits run out – especially in the case of cancer, because the treatment is lengthy and costly. Although the waiting lists for the treatment of cervical cancer in the public sector may be long, the services provided are often of a high quality.

On the prevention front, two drug companies have developed anti-HPV vaccines to prevent cervical cancer. The April 2005 issue of the journal *Lancet Oncology* reported that one of these vaccines, which targets the four strains of HPV that are most likely to cause cervical cancer, was 89% effective in preventing HPV infection in the first place and 100% effective in preventing cervical cancer, pre-cancerous lesions or genital warts.

In 2006 the vaccine was registered for use in the US and the European Union. However, based on gender stereotypes and prejudices, there has been opposition to the use of the vaccine from groups who believe that it will simply encourage young girls to have more sex. For the vaccine to be of most benefit, it will have to be administered to young girls before they commence having sex. Its availability on the market may therefore not necessarily lead to widespread availability, particularly given the Bush administration’s
promotion of abstinence as the primary form of protection against sexually transmitted infections, including HPV and HIV.

In South Africa, however, such arguments would not find favour with our Constitution. Once registered for use in this country, government would be wise to embark on a widespread anti-HPV vaccination campaign.

**BREAST CANCER**

While there are no known ways of preventing breast cancer, which can develop quite rapidly, the earlier it is detected, the earlier it can be treated. While the causes of breast cancer remain uncertain, known risk factors make some women more vulnerable to breast cancer. The most direct and well-documented risk is a family history of breast cancer.

Points to remember:

- Health education should inform all women on how to do regular breast self-examinations to detect any lumps and be aware of the dangers of breast cancer.
- When breast cancer is suspected, a woman should get medical attention immediately and discuss treatment options with her health care worker. Regrettably, there is no government policy on breast cancer screening. The PMBs for treatable breast cancer cover medical and surgical management, including chemotherapy and radiation therapy.

**Termination of pregnancy**

**CHOICE ON TERMINATION OF PREGNANCY ACT**

The Choice on Termination of Pregnancy Act, 92 of 1996 (CTOP) gives significant effect to the rights of reproductive choice set out in the Constitution. In contrast to the Abortion and Sterilisation Act, 2 of 1975 that criminalised abortion except under very limited circumstances, CTOP makes it possible for all women to choose to have an abortion.

CTOP was passed as a result of:

- the immense dangers of "back street abortions" (abortions done illegally, usually by unqualified people); and
- the importance of giving substance to women’s constitutional rights to reproductive health care, privacy and bodily autonomy.
Abortion is now a possibility for most women or girls who have an unwanted pregnancy. Abortions can be done at an accredited clinic or hospital by a doctor or registered midwife, who has completed a training course in abortion.

Women should be able to receive counselling on abortion and the procedure, but may choose not to have counselling.

Girls under 18 may obtain an abortion without their parents’ consent. CTOP requires that a minor be counselled on the importance of discussing the issue with someone she trusts, but does not make it a precondition for abortion.

Key Point: What the Act provides

Any girl or woman can choose to have an abortion in the first three months of pregnancy, regardless of her reason for seeking the abortion.

After the first three months (13th to 20th weeks), the woman can terminate her pregnancy only if her doctor thinks that:

- continued pregnancy would risk the physical and/or mental health of the woman;
- there is a substantial risk that the foetus would suffer a severe physical or mental abnormality;
- the pregnancy is as a result of rape or incest; or
- the pregnancy will significantly affect the woman economically and/or socially.

An abortion is legal after the 20th week of pregnancy if a doctor – consulting with another doctor or registered midwife – thinks that if the pregnancy continues:

- the woman’s life would be at risk;
- the foetus will be severely malformed; or
- the foetus would face a risk of injury.

The Choice on Termination of Pregnancy Amendment Act, 38 of 2004 contains provisions that make abortion services more accessible to women by allowing:

- registered nurses, who have been trained to perform abortions, to carry out their responsibilities
- less strict requirements for facilities to obtain accreditation to perform abortions.

Unfortunately, in August 2006, the Constitutional Court in a case known as *Doctors for Life International v The Speaker of Parliament and Others* declared this amendment to the Act unconstitutional on the grounds that there had not
been a full process of public consultation. The Court ordered the government to refer the Act back to Parliament “to enable it to re-enact these statutes in a manner that is consistent with the Constitution”. However, because the Act had already taken effect, it suspended its order of invalidity for 18 months, so as to allow sufficient time for the Act to be passed once more.

## CASE STUDY: OTHER CHALLENGES TO CTOP

Some groups were angered by the Choice on Termination of Pregnancy Act and challenged its constitutionality in court:

- In the 1998 case of *Christian Lawyers Association of South Africa v Minister of Health*, the Christian Lawyers Association (CLA) asked for a court order declaring CTOP, in its entirety, unconstitutional and therefore invalid. In dismissing their challenge, the Pretoria High Court rejected their argument that the foetus had the right to life under section 11 of the Constitution (*Christian Lawyers Association of SA and others v Minister of Health and others* 1998 (4) SA 1113 (T), 1998 BCLR 1434 (T)).

- In 2001, the CLA launched another action against CTOP. In the case of *Christian Lawyers Association of South Africa v Minister of Health, Premier of Gauteng and Health MEC*, the CLA argued for imposing a number of restrictions on a minor’s choice of having an abortion, including the requirement of consent or consultation with her parents. The court dismissed the CLA’s claim. (*Christian Lawyers Association of SA and others v Minister of Health and others* 2005 (1) SA 509 (T), 2004(10) BCLR 1036 (T))

Point to remember: Free terminations

Under section 4(3)(c) of the National Health Act 61 of 2003, women have a right to free termination of pregnancy services. Under the PMBs, women have the right to an induced termination of pregnancy and medical and surgical management

### Contraception and family planning

The term contraception refers to methods of birth control that allow women and men to decide whether they want children; how many children they want and when. Having access to contraceptives is thus a vital part of giving effect to the reproductive and sexual rights of men and women. Contraceptive and family planning services are supposed to be a part of primary health care services that are free of charge to all public health system users. Women and men thus have a right to receive contraception free of charge.
CONTRACEPTION GUIDELINES

The National Contraception Policy Guidelines (2002) set out comprehensive principles and strategies to improve reproductive health. In particular, they emphasise that access to information regarding reproductive health is vital for the realisation of these rights.

The Guidelines say that these “core” methods should be in stock and available at all health facilities:
- Male condoms.
- Oral contraceptives.
- Progestogen-only injectables.
- Emergency contraception.

The majority of women who use contraception in South Africa obtain it from the public sector. Injectable progestogen (a hormone that is injected every three months) is still the most highly used method. According to the Department of Health, emergency contraception (the "morning-after pill") is now available over the counter in pharmacies under pharmacist supervision.

CONDOMS

In 2005 the DoH estimated that it distributed about 30 million free male condoms every month. Female condoms, however, are not freely available at all clinics and hospitals, and in 2005 less than 1.5 million were distributed in total. This is a stark example of the inequality that exists in access to reproductive health care.

STERILISATION

Sterilisation is a procedure done on a man or a woman to ensure that he or she cannot have any more children. The procedure is generally considered to be permanent and usually cannot be reversed.

The Sterilisation Act 44 of 1998 regulates sterilisation in South Africa. This law says that no one who is over 18 and who is capable of consenting to sterilisation may be prohibited from having a sterilisation performed. New provisions in the Sterilisation Amendment Act, 3 of 2005 provide for the sterilisation of a person in circumstances where the person’s mental or physical health is threatened, and where the sterilisation is in the best interests of the person.
MALE CIRCUMCISION

The Children’s Act, 2005, prohibits circumcision of male children under 16 “except in accordance with the practices of ... religion” or “for medical reasons” (see Chapter 9, page 308). The main purpose of this section was to protect young males from being coerced into traditional circumcision without their consent. In addition several provinces have passed laws to regulate the practice of traditional circumcision, mainly to ensure safety. However, the Department of Heath does not have a general policy on male circumcision as it relates to reproductive health.

This is likely to change soon, mainly because in late 2006 two medical trials investigating the link between male circumcision and risk of HIV infection, showed definitively that men who are circumcised have a significantly lower risk of being infected with HIV. This means that circumcision will be recommended as a major HIV prevention strategy.

Sexually transmitted infections (STIs), including HIV infection

There are biological, social and economic reasons why women are generally more vulnerable to contracting STIs and HIV. Women’s relative lack of power in society and in relationships may make it difficult for them to determine where, when and with whom to have sex, as well as how – with or without condoms, for example. This increases their risk of being exposed to STIs or HIV.

In addition, it is harder for women to know when they have contracted an STI and have it treated:
- Many STIs are asymptomatic in women, whereas in men they often present obvious symptoms.
- Even where there may be evidence that an STI is present, some women have never been taught how to differentiate between healthy and unhealthy vaginal secretions, or may consider abnormal discharge to be acceptable.

The presence of many STIs – such as herpes – increases people’s risk of contracting HIV, so early detection and treatment of STIs is vital. More needs
to be done by all, including government and civil society, to ensure that all people – and women in particular – are able to identify and in a position to seek help for STIs.

**Microbicides**
Research to develop vaginal and rectal *microbicides* is currently underway in many parts of the world. If and when developed, microbicides – primarily in the form of gels, creams or tablets – are expected either to destroy bacteria, viruses or other microbes, or to prevent them from entering human cells and causing harm. For example, an HIV microbicide will either destroy HIV in the semen or prevent HIV infection.

A number of clinical trials are currently being conducted in South Africa and elsewhere. However, it is unlikely that a safe and effective microbicide will be available until at least 2010, and possibly even later. But if and when they become available, they will provide women (and possibly even gay men and other men who have sex with men) with further prevention tools – to be applied to the vagina or the rectum before sex – with or without the knowledge of the partner – in order to reduce the risk of HIV or STI transmission.

**Key Point: Female-controlled prevention method**
Microbicides will be a female-controlled method of HIV prevention – in other words, women will be able to protect themselves against HIV without first having to obtain the consent from their male partners, or even having to inform them about its use.

**Prevention of mother-to-child-transmission of HIV (PMTCT)**
The increasingly high prevalence of HIV in South Africa means that tens of thousands of women with HIV/AIDS who give birth each year run the risk of passing HIV on to their newborn babies. The 2005 *National HIV and Syphilis Antenatal Sero-prevalence Survey in South Africa* found that 30.2% of pregnant women attending public antenatal clinic surveys were HIV positive in 2005 (see chart below).
There are a number of ways in which women can reduce the risk of transmitting HIV to their babies. Strategies include:

- the taking of ARV medicines by the mother, either as ARV treatment for herself or during the last few weeks of pregnancy and/or labour, as well as by the newborn child;
- birth by caesarean section; and
- formula-feeding wherever possible (such as where safe drinking water is available), or else exclusive breast-feeding.

In October 2000, the DoH released a document called *Prevention of Mother-to-Child HIV Transmission and Management of HIV Positive Pregnant Women*. This document aimed to support its *Guidelines for Maternity Care*. The biggest gap in the DoH’s PMTCT document was that it did not give women the option of using ARV medicines to reduce the risk of HIV transmission to their newborn babies. In response to immense national and international public pressure, spearheaded by the Treatment Action Campaign (TAC), government embarked on a limited PMTCT programme – only two sites per province were entitled to prescribe and dispense the ARV nevirapine for use in PMTCT. There was no indication of if and when the programme would be expanded to ensure universal access.

Consequently, the TAC took the matter to court, resulting in a Constitutional Court decision handed down in July 2002 instructing the government to implement a comprehensive PMTCT programme, including the use of ARV medicines, as a matter of urgency. As a result, the PMTCT programme was thereafter expanded beyond the initial limited number of pilot sites. By 2005, according to the DoH more than 87% of health facilities offered PMTCT services. However, although this appears impressive, implementation has been poorly managed. In addition,
once again the government has lagged behind international recommendations on steps to take to PMTCT. For example, in 2006 the WHO revised its guidelines on PMTCT, recommending that ARVs be provided to pregnant women from the 28th week of pregnancy. In eight out of nine provinces, however, SA still only gives nevirapine to mothers at the point when they go into labour.

The PMBs also include PMTCT for pregnant women with HIV.

**BREASTFEEDING**

The *Policy Guideline and Recommendation for Feeding of Infants of HIV-positive Mothers* (2000) makes it clear that breastfeeding by mothers with HIV/AIDS poses a risk of HIV transmission. It also points out the dangers of water-borne diseases when formula is mixed with unclean water. The Guideline therefore recommends that:

- Women should be counselled about the risks of breastfeeding (HIV transmission) and the risks of formula feeding using unclean water (water-borne diseases).
- Women should be enabled to make the best decision for their particular circumstances.
- Mothers must be provided with ongoing support, whatever their decision.

**AIDS LAW PROJECT: SUBMISSION ON BREASTFEEDING**

In a 2003 submission on the draft amendment, the ALP expressed concern that “the Regulations promote breastfeeding and regulate the feeding of infants in general, whilst a separate policy deals with infant feeding in relation to mothers with HIV.” The ALP warned that without adequate information on the risks and benefits of breastfeeding in the context of the HIV epidemic, health care workers find it difficult to provide the necessary support to women with HIV to assist them to make the correct decision about infant feeding.

The ALP made a number of suggestions on how the Regulations could be responsive to the epidemic, such as the need to:

- Develop a comprehensive national infant and young child feeding policy.
- Implement and enforce the International Code of Marketing of Breast-milk Substitutes.
- Provide adequate support to women with HIV to enable them to select and implement the best feeding option for themselves and their babies.

Points to remember: Exclusive breastfeeding

- For women with HIV who choose to breastfeed, the Guidelines point out that it is essential that they exclusively breastfeed.
They should not provide mixed feeding (as many HIV-negative women do) because this increases the vulnerability of infants to contracting HIV. *Mixed feeding* is the combination of breastfeeding, formula feeding and/or any other non-breastfeeding option. *Exclusive breastfeeding* means that the baby should not even be given water from a bottle, as the water may be contaminated.

In 2003, the DoH published draft amendments to the regulations that govern formula-feeding. The draft *Regulations relating to Foodstuffs for Infants and Young Children* recommended breast-milk for infants, without giving proper attention to the risk of HIV transmission through breast-milk.

**Maternal health**

Women who are pregnant (and those who have just given birth) have a range of unique health needs. Good medical care in hygienic conditions can reduce the risk of complications and infections in both the mother and baby, and should be available to all women.

In South Africa, more than 90% of pregnant women attend antenatal care services. Furthermore, section 4(3)(a) of the National Health Act mandates public sector clinics and community health centres to provide free health care services to all pregnant and lactating women (women who are breastfeeding) who do not have medical scheme coverage. Nevertheless, a disturbing number of women still die as a result of complications during pregnancy and childbirth. The maternal mortality ratio (MMR) is the indicator used to describe maternal deaths. It is defined as the number of maternal deaths for every 100 000 live births.

According to WHO, UNICEF and UNFPA estimates, South Africa’s MMR in 2000 was 230, meaning 230 maternal deaths for every 100 000 live births. This compares somewhat favourably with the world average MMR of 400 deaths, and very well with the 910 MMR in Africa during the same period. However, when compared to other middle-income countries, South Africa is not doing well. In particular, a number of lower-middle income countries achieved a much lower MMR in 2000: Ukraine (37), China (56), Cuba (33) and Thailand (44).

**Points to remember: Reducing maternal deaths**

- The vast majority of maternal deaths are preventable.
- Co-ordinated efforts and increased access to an adequate and comprehensive maternal health service can dramatically improve a country’s MMR.
- Maternal deaths continue to happen because of poor access to health services and women’s lack of access to information.
According to the DoH (Saving Mothers - Policy and Management Guidelines for Common Causes of Maternal Deaths, 2001 and Saving Mothers - Report on Confidential Enquiries into Maternal Deaths in South Africa, 1999; 2003; 2006), the five main causes of maternal death in South Africa over the last ten years have been:

- Hypertensive conditions (high blood pressure) in pregnancy: 19.1% in 2002-2004.
- Pre-existing cardiac (heart) disease: 5.6% in 2002-2004.

The Guidelines for Maternity Care in South Africa – A manual for clinics, community health centres and district hospitals of 2002 and Saving Mothers - Policy and Management Guidelines for Common Causes of Maternal Deaths of 2001 give detailed direction to health care workers on preventing maternal deaths. Emphasising that one of the major areas of substandard care is the poor initial assessment of the patient, they provide guidance on a range of issues including:

- clinical signs;
- procedures for special investigations into a problem;
- supportive treatment;
- referral criteria;
- essential screening investigations; and
- emergency transport.

In 2006, however, the DoH amended its guidelines to take account of the growing number of maternal deaths attributed to HIV. It made two important new recommendations that should be implemented in the health service. These were that:

1. “Protocols on the management of important conditions causing maternal deaths must be available and utilised appropriately in all institutions where women deliver. All midwives and doctors must be trained on these protocols.”
2. “All pregnant women should be offered information on, screening for and appropriate management of communicable and non-communicable diseases.”
Infertility

Infertility means not being able to produce children. A couple is considered infertile when they have not conceived a baby after twelve months of regular unprotected sexual intercourse, or six months if the woman is older than 35.

Infertility is a common problem in South Africa and one that is often not acknowledged. A number of ethnic groups attach great importance to having children and this places great pressure on women to bear children. Women who can’t have children often experience social isolation, stigma, psychological and even physical abuse, as it is often automatically assumed that the problem lies with them. This is despite the fact that the medical problem may lie with either the woman or the man, or both.

A number of factors can give rise to infertility in women. One of the most common causes of infertility is pelvic inflammatory disease, a long lasting infection that affects the womb, the fallopian tubes (which deliver eggs to the womb) and the nearby structures in the lower abdomen. Pelvic inflammatory disease is often caused by STIs or an unsafe termination of pregnancy. On their own, untreated STIs may also cause of infertility. This means that one way to reduce infertility is to ensure that women generally practise safer sex, as well as to ensure that STIs are detected and treated early.

There is no national policy on infertility, and fertility services are available only at a few tertiary public hospitals. People who can access the private sector may make use of assisted conception procedures, such as in vitro fertilisation (IVF) and intrauterine insemination (IUI). IVF is a procedure where a woman’s (or a donor’s) eggs and her partner’s (or a donor’s) sperm are collected and mixed together in a laboratory to achieve fertilisation outside the body. The embryos produced may then be transferred into the women’s womb. IUI is performed by threading a very thin flexible catheter (small pipe) through the cervix and injecting washed sperm (sperm that has been separated from semen) directly into the uterus of a woman. These procedures are very expensive.

11.4 Social factors that affect women’s health

Gender-based violence

South Africa has one of the highest levels of gender-based violence in the world. Gender-based violence is violence that is mainly aimed at women, and
comes from the unequal power relations between men and women. It includes domestic abuse or ‘battering’, rape and sexual assault, as well as a number of other violent acts that cause harm to women.

Gender-based violence directly affects the physical and mental health of many women. Many women and girls need specialised medical care and psychosocial support for the injuries they sustain. According to Human Rights Watch, domestic violence is the leading cause of injuries to women in most countries in the world.

### The UN Commission on Human Rights defines violence against women as follows:

“Violence against women means any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life, and including domestic violence, crimes committed in the name of honour, crimes committed in the name of passion, trafficking in women and girls, traditional practices harmful to women, including female genital mutilation, early and forced marriages, female infanticide, dowry-related violence and deaths, acid attacks and violence related to commercial sexual exploitation as well as economic exploitation.”

Source: *Elimination of Violence against Women: Resolution, 2003*

### Rape and sexual assault

South African law currently defines:

- **Rape** as “intentional, unlawful sexual intercourse with a woman without her consent”
- **Indecent assault** as including non-consensual anal intercourse, as well as non-consensual anal or vaginal penetration by objects.

There are different punishments for these defined acts of violence, as well as different social consequences. Gender activists are dissatisfied with the current narrow definition of rape and argue that all sexual assault should be included under an amended definition of rape.

It is hoped that the draft Criminal Law (Sexual Offences) Amendment Bill, which was approved by Cabinet on 3 May 2006 but (at the time of writing) has not yet been tabled in Parliament, will amend the definition of rape, in part by broadening it to include various forms of sexual assault. An earlier version of the draft Bill (B50 of 2003) proposed the following definition of rape:
“A person who unlawfully and intentionally commits an act which causes penetration to any extent whatsoever by the genital organs of that person into or beyond the anus or genital organs of another person, or any act which causes penetration to any extent whatsoever by the genital organs of another person into or beyond the anus or genital organs of the person committing the act, is guilty of the offence of rape.”

**Criminalising Non-Disclosure of HIV Status?**

An early draft of the Bill (B50 of 2003) proposed criminalising the non-disclosure of HIV status. If such a proposal is reintroduced and becomes law, it will mean that:
- A person who knows that he or she is HIV positive, will have to tell his or her sexual partner his or her HIV status before having sex.
- If he or she does not, he or she may be charged with an offence, even if his or her partner did not get HIV from her.

If passed, such provisions may create a number of problems for women in particular:
- Many women are afraid to disclose their HIV status to their partners for fear of violence and/or abandonment.
- The proposed provisions may actually discourage people from finding out their HIV status, as it may count against them later on.

It is the very fear of domestic violence that prevents many women from accessing voluntary counselling and testing (VCT) for HIV, obtaining information about (or treatment for) HIV and STIs, and saying no to sex or unsafe sex.

There are a number of services and remedies that survivors of rape or domestic violence are entitled to in South Africa. We will discuss:
- The Domestic Violence Act.
- Rape and sexual assault services.

**Domestic Violence Act**

The Domestic Violence Act, 116 of 1998, which recognises that domestic violence is a “serious social evil”, has broadened the definition of the offence to include certain categories of harmful conduct against all partners in intimate relationships. In terms of the new definition, domestic violence includes:
- any “controlling or abusive behaviour, where such conduct harms, or may cause harm to the safety, health or well-being of the complainant”;
- and
- physical, sexual, emotional and economic abuse, as well as stalking and intimidation.
Any person who experiences domestic violence may apply to a court for a protection order. According to National Instruction 7/1999 issued in terms of the Domestic Violence Act, it is the duty of a police officer to:

- secure the scene of domestic violence
- give general assistance to the complainant, including finding a suitable shelter
- help the complainant to get medical treatment.

**Rape and sexual assault services**

A number of government departments and agencies have issued guidelines on the management of survivors of sexual assault. These are listed below:

- **Department of Health:**
  - *Uniform National Health Guidelines for Dealing with Survivors of Rape and other Sexual Offences*
  - *Policy Guideline for Management of Transmission of Human Immunodeficiency Virus (HIV) and Sexually Transmitted Infections in Sexual Assault*
  - *Victims of Sexual Abuse, Domestic Violence and Gender Violence – the Primary Health Care Package for South Africa: A Set of Norms and Standards*

- **South African Police Services:**
  - *Support to Victims of Sexual Offences*

- **Department of Justice:**
  - *National Guidelines for Prosecutors in Sexual Offence Cases*

- **Department of Social Development:**
  - *Procedural Guidelines to Social Welfare Agencies and Appropriate NGOs in Assisting Victims of Rape and Sexual Offences*

Collectively, these Guidelines impose various duties on the police, health care workers and others who are tasked with providing services to survivors of sexual assault. Importantly, these guidelines require co-operation between the health, justice, social development and safety and security (police) sectors. The Guidelines give survivors of sexual assault the right to:

- Counselling.
- Referrals.
- STI prophylaxis.
HIV prophylaxis (in other words, PEP).
- Emergency contraception.
- Care of injuries.
- Medico-legal advice.
- Proper documentation of their evidence.

In the private sector, the PMBs for the medical care of survivors of sexual assault include access to PEP, medical management and psychotherapy.

**Compulsory testing for HIV?**

If enacted and brought into force, provisions in the draft Criminal Law (Sexual Offences) Amendment Bill would allow for:
- Alleged rapists and other perpetrators of sexual assault to be tested for HIV, without their consent, solely at the request of the survivor of rape or sexual assault;
- The results of the HIV test to be made known to the survivor alone; and
- The results also to be made known to the suspect if he wants to know his HIV test result.

If the Bill becomes law, it will be an offence for the survivor to disclose the HIV status of the suspect to any other person. In addition, it would not be possible to use the results of the HIV test in the criminal case against the suspect. In other words, the compulsory testing would simply be to ensure that the complainant has knowledge of the alleged offender’s HIV status for his or her peace of mind and/or to enable him or her to make health care choices, such as taking post-exposure prophylaxis (PEP) to prevent HIV transmission.

**Employment and health**

There are protections in the law that are aimed at ensuring that women do not face unfair discrimination in the workplace because of their reproductive choices, and that employment does not prevent women from accessing appropriate antenatal care or choosing to breastfeed.

The Labour Relations Act 66 of 1995 (LRA), provides that a dismissal of an employee because of pregnancy, an intended pregnancy or any reason related to her pregnancy is regarded as “automatically unfair”. The LRA also regards the refusal of a woman to come back to work after her pregnancy as a dismissal.

In terms of the Basic Conditions of Employment Act 75 of 1997, women have the following pregnancy-related rights in the workplace:
- A pregnant woman has the right to four consecutive months’ unpaid maternity leave.
- She can take maternity leave at any time from four weeks before the expected date of birth, or at any date stipulated by her doctor or midwife.
- No woman may work for six weeks after the birth of a child (including a
miscarriage in the third trimester or a still-born child), unless a medical practitioner or midwife declares that it is safe for her to work.

Before taking maternity leave, a pregnant employee must notify her employer – in writing – of the date upon which she plans to leave and when she intends to return to work. If she has contributed to the Unemployment Insurance Fund (UIF), she is entitled to access UIF benefits during this period, provided she makes an appropriate application to the Department of Labour. These employment benefits assist women in the workforce to look after their own and their children’s health in the potentially vulnerable time after birth when they are not working.

A Code of Good Practice on the Protection of Employees during Pregnancy and after the Birth of a Child was issued in terms of the BCEA in 1998. It sets out a number of guidelines on how to make the workplace safer for pregnant women and those women who have just given birth, in order to give effect to the provisions in the BCEA that relate to these issues.

According to section 26(1) of the BCEA, employers may not require pregnant women or women who are breastfeeding to perform work that is hazardous to their health. According to the Code, this means that:

- Employers have to assess and control occupational risks that could endanger the health of pregnant women, women of a childbearing age and breastfeeding women.
- Employers must take into account and accommodate common aspects of pregnancy that will have an impact on a pregnant employee’s work environment and performance.

Examples: Pregnancy factors to accommodate

- Morning sickness.
- Backache.
- Frequent visits to the toilet.
- Affected sense of balance.
- Tiredness.

If an employer does not follow the standards set out in the BCEA and the Code of Good Practice, the employee should:

- inform her union;
- lay a complaint with the Department of Labour; or
- take legal action in the Labour Court.
11.5 Other important gender issues

Gay men, lesbians, MSM and WSW

Definitions
A gay man is a man who is sexually and emotionally attracted to other men. Similarly, a lesbian is a woman who is sexually and emotionally attracted to other women. Some lesbians, however, prefer to be referred to as gay women. People who are sexually and emotionally attracted to both sexes are known as bisexual.

Those men who are sexually attracted to other men, and indeed have sex with them but do not necessarily identify as gay, are known as men who have sex with men (MSM). Similarly, women who are sexually attracted to other women, and indeed have sex with them but do not necessarily identify as lesbian, are known as women who have sex with women (WSW). For the purpose of this section, however, we simply refer to gay men and lesbians.

Access to health care services
Actual or perceived homophobia and unfair discrimination on the basis of sexual orientation may adversely affect the health-seeking behaviour of gay men and lesbians, or else limit their access to appropriate health care services. This can happen in a number of ways, such as by:

- preventing them from disclosing any information about their sexual activity where this may be relevant for the purposes of diagnosis, health promotion and/or treatment options; or
- preventing them from seeking information on sexual health services as well as information on the prevention and treatment of STIs, including HIV.

Unfortunately, access to health care services for gay men and lesbians may also be limited in numerous other ways. Usually, this is not because of direct discrimination, but rather because of a failure to consider the specific health needs of lesbians and gay men. Because they are also women, lesbians simply have to make do with health services that are made available for women. Similarly, gay men are often treated simply as men, even if they have specific health needs that differ from heterosexual men.
Consider, for example, that there is very limited research and information on gay men’s health in South Africa, even in the field of HIV/AIDS. Unprotected anal sex, which is often practised by many gay men (as well as some heterosexuals), carries a much higher risk of HIV infection than does unprotected vaginal sex. This is primarily because it carries a greater risk of tissue tearing, thereby providing an entry point for HIV into the cells. Yet we have no statistics on HIV prevalence or incidence amongst gay men. In addition, there are very few dedicated HIV prevention services for gay men.

**Commercial sex workers**

In South Africa, commercial sex work (prostitution) is illegal. Its criminalisation, however, does little to stop it from existing. Instead, it simply makes it extremely difficult for sex workers to get the protection of the law, making them particularly vulnerable to sexual abuse and others forms of gender-based violence. Although both men and women sell sex, the vast majority of sex workers in South Africa are women.

But the nature of their work – potentially being in frequent contact with the body fluids of a range of people – increases their risk of contracting HIV and other STIs. In turn, their increased risk of infection increases the risks faced by

**CASE STUDY: CRIMINALISATION OF SEX WORK**

In the 2002 case of *S v Jordan* 2002 (6) SA 642 (CC), the constitutionality of the provisions of the Sexual Offences Act 23 of 1957 criminalising sex work were challenged. In particular, the Constitutional Court considered section 20(1)(aA) of the statute, which criminalises performing sex for reward.

In its decision, the Constitutional Court found as follows:

- A narrow majority (five judges) of the Court upheld the constitutionality of section 20(1)(aA), with the other four judges who heard the case finding that the provision unreasonably and unjustifiably limits the rights of sex workers to non-discrimination on the basis of gender.

- All nine judges agreed that the provision does not violate the rights of sex workers to human dignity and free economic activity. According to the Court, even if section 20(1)(aA) limits the right to privacy, it is not unconstitutional as the limitation is both reasonable and justifiable according to the test set out in section 36(1) of the Constitution.

- The Court made it clear that Parliament is in a better position to deal with the complex issues that arise with sex work.

A serious shortcoming in both judgments is that neither deals with the implications of the criminalisation of sex work for the health of sex workers. This is probably because the case was argued under the 1993 interim Constitution, which did not recognise a right of access to health care services, as is the case with the 1996 Constitution.
the regular sexual partners of their clients, including wives and girlfriends. Yet the criminalisation of sex work – as well as the stigma that is associated with it – makes it far more difficult for sex workers to access health care services. This makes it especially important when sex workers are able to access health care services, that they be treated with dignity and empathy.

Possible law reform

The South African Law Reform Commission (SALRC) has been mandated to investigate the need to revise the laws that relate to adult sex work and to make recommendations on how the current laws can and/or should be reformed. In essence, the SALRC will have to decide whether all or certain aspects of sex work should be criminalised, legalised or decriminalised. It could, for example, decide to criminalise the purchasing of sex in the same way that it currently criminalises the selling of sex. Or it could decide to regulate sex work and allow for it to take place under certain strict conditions. Finally, it could decide to regard sex work as any other form of work, removing the laws that make it a crime for adults to sell sex. This process is likely to still take several years to complete.

Points to remember: Rights of sex workers

- In spite of the heavy social stigma of sex work and its criminalisation by law, all sex workers have a right to the same standard of health care and assistance as other users of the health care system.
- Where sex workers experience discrimination or ill treatment from health care workers, this should immediately be reported to the Health Professions Council or the South African Nursing Council. However, it is quite possible that complaints lodged by sex workers – if known to be sex workers – will not be treated with the respect and seriousness that they deserve.

11.6 Conclusion

We have seen that it is not only biological or anatomical differences between men and women that affect a woman’s or a man’s health. For women, gender-based violence and economic disempowerment are equally important factors that influence health. While there have been laws that are aimed at addressing these issues, the inequalities are still great. Tragically, some customary practices and traditions reinforce the inequalities.
With regard to men, we find poor health-seeking behaviour. While women often seek health services at the time of pregnancy or when they bring their children to health facilities, men often seek health services only when they are very ill. Because of harmful gender stereotypes, men may feel uncomfortable with using health services as they regard it as a sign of weakness. In the case of HIV this has meant more women than men knowing their HIV status, with more women accessing ARV treatment in the public sector.

We have also seen that there are international and national laws that prohibit discrimination on the basis of sex and gender and/or promote gender equality. Some laws, such as the Choice on Termination of Pregnancy Act, actively seek to ensure that women are able to make their own informed decisions regarding reproductive health. This increases their ability to participate equally in society.

However, improving the law – while essential – will not be sufficient to address the problematic relationship between gender and health. It is required of civil society, the state, religious groups and families to alter the stereotypes that exist in society and actively to promote the fundamental right to gender equality. This is necessary in order to ensure that all people, regardless of sex or gender, have equitable access to appropriate, high quality health care services.