

# Equal Access to Health Care Services for Survivors of Gender-Based Violence: A South African Perspective

Tarryn Bannister<sup>1</sup>

## 1. Introduction

Gender-based violence (GBV)<sup>2</sup> has been described as the most widespread and socially tolerated of human rights violations.<sup>3</sup> This appears justified as, globally, more girls have been killed in the last 50 years, simply because they were girls, than men were killed in all the battles of the twentieth century.<sup>4</sup> Due to the fact that women and girls remain disproportionately affected by GBV,<sup>5</sup> this article primarily focuses on the needs of female survivors of GBV (SGBV). In relation to South Africa, statistics for the year 2012 revealed that a woman was murdered every eight hours by her intimate partner.<sup>6</sup> Rape homicides have also increased annually within South Africa since 1999,<sup>7</sup> while 66,387 sexual offences were reported to the South African Police Services during the year of 2013.<sup>8</sup> This is an alarmingly high number when one considers that sexual offences are notoriously underreported.<sup>9</sup> There are other forms of GBV currently plaguing South Africa, such as sexual harassment, stalking, corrective rapes, human trafficking and female genital mutilation, for which there are currently no reliable statistics. This is indefensible given the extreme levels of this violence, as well as the devastating consequences for women. The need to effectively address this epidemic is further justified by the Constitutional commitment to substantive equality,<sup>10</sup>

freedom from public and private violence<sup>11</sup> and justiciable socio-economic rights.<sup>12</sup> In spite of these progressive provisions, however, certain gaps within South Africa's legal framework remain, effectively undermining the constitutional rights of abused women. For example, it is submitted that the interrelationship between the constitutional right to equality and the socio-economic rights has not been sufficiently recognised and addressed by the state. This is problematic as women's poverty reinforces their social subordination, making them more vulnerable to violence and exploitation.<sup>13</sup>

In particular, the interconnection between the right to equality and the right to have access to health care services, including reproductive health care,<sup>14</sup> has not been fully utilised when addressing GBV. Developing this interrelationship is, however, of the utmost importance as GBV is both a human rights issue and a public health crisis. This article therefore highlights the negative health consequences of GBV. This is then followed by an overview of the constitutional normative framework, focusing on how interpretations of the right to equality and the right to have access to health care services have not been sufficiently responsive to the specific needs of women. This is

subsequently followed by an examination of existing gaps within health care legislation and policy that effectively neglect the health care needs of abused women. In conclusion, this article argues that in order to give effect to the transformative potential of the right to equality, it needs to be interpreted in a manner that is more responsive to the feminisation of socio-economic burdens.<sup>15</sup> Similarly, in order to give effect to the constitutional right to have access to health care services, it needs to be interpreted in a manner that gives effect to substantive equality, which embraces the idea of taking positive steps to redistribute power and resources in order to eliminate disadvantage.<sup>16</sup> This article therefore examines how substantive equality, with its focus on context, the impact of legal provisions, a positive recognition of difference and a reliance on values, can be streamlined into the reasonableness review model for adjudicating socio-economic rights. This article then posits that the right to substantive equality should be utilised to inform health care legislation and policy so as to reflect the specific needs and experiences of SGBV. This is of vital importance as timely access to quality health care interventions can assist in preventing future acts of violence, while reducing the risk of long-term health complications. For example, quality counselling services can assist in breaking the psychological pattern of abuse,<sup>17</sup> while timely access to post-exposure prophylaxis (PEP) can prevent the transmission of HIV/AIDS. However, in spite of this potential, the right to health is not currently being fully utilised. It is therefore submitted that an interdependent understanding of the right to equality and the right to have access to health care services needs to inform the development of a comprehensive evidence-based plan to adequately prevent, address and respond to GBV.<sup>18</sup>

## 2. GBV as a Public Health Crisis

GBV is both a human rights issue and a public health crisis with devastating health consequences. For example, GBV kills and disables as many women between the ages of 15 and 44 as cancer does.<sup>19</sup> Its toll on women's health also surpasses that of traffic accidents and malaria combined,<sup>20</sup> while serving as a leading cause of death and disability for women.<sup>21</sup> Specific examples of fatal health outcomes include AIDS-related mortality, maternal mortality, homicide and suicide.<sup>22</sup> Non-fatal consequences include bone fractures, haemorrhaging, gastrointestinal problems, central nervous system disorders, chronic pain, sexual and reproductive health problems and mental illness.<sup>23</sup> Health care services therefore need to be strengthened in order to mitigate these consequences while possibly preventing the escalation of violence.<sup>24</sup>

In relation to reproductive health, GBV can result in HIV/AIDS infection, unwanted pregnancy, induced abortion and sexually transmitted infections and diseases.<sup>25</sup> Cervical cancer has also been linked to domestic violence.<sup>26</sup> Given that women are already physiologically more susceptible to HIV/AIDS infection,<sup>27</sup> GBV has exacerbated this vulnerability, resulting in HIV/AIDS becoming a gendered epidemic. These biological vulnerabilities also intersect with gendered social roles. For example, the gendered division of labour results in the vast majority of poverty-stricken women being primarily responsible for child care and domestic work. While this work is rewarding, it is often undervalued, effectively preventing women from participating within the labour market on an equal basis.<sup>28</sup> This undermines their socio-economic power and consequently restricts their ability to negotiate condom usage, to control the number and spacing

of their children and to allocate resources to necessary health care services.<sup>29</sup> It is not surprising then that GBV can result in severe depression, sleep disorders, anxiety and post-traumatic stress disorder.<sup>30</sup> This, therefore, reveals that GBV has a devastating impact on the health and well-being of women. SGBV accordingly require a myriad of health care services, such as emergency contraception, HIV/AIDS prevention services (including screening for PEP), and the management of psychological health care problems. They also require screening programmes to identify survivors of domestic violence as well as screening programmes for cervical and breast cancer. However, in spite of this reality, this violence continues to be neglected, under-documented and under-reported by the South African health care system.<sup>31</sup>

### **3. South Africa's Relevant Legal and Policy Framework**

#### *a) The Normative Constitutional Framework*

In 1996 the South African legal system underwent a major structural and normative change from a system of parliamentary sovereignty, which existed under apartheid, to a system of constitutional democracy, with an entrenched and justiciable Bill of Rights. The Constitution therefore serves as the supreme law of the Republic, while the courts have the power to declare invalid any law or conduct inconsistent with the fundamental rights protected within the Bill of Rights. While it is true that the law alone cannot create all of the social change that is required,<sup>32</sup> legislation and policy for SGBV can be further infused with the fundamental human rights principles that are protected within the Constitution. For example, equality is included in the Constitution as both a value and a right. The founding values underlying the Constitution are human dignity, equality and freedom, as

well as non-racialism and non-sexism.<sup>33</sup> As a right, section 9(1) provides that everyone is equal before the law, and that everyone has the right to equal protection and benefit of the law. Section 9(2) goes on to specifically state that:

“Equality includes the full and equal enjoyment of all rights and freedoms. To promote the achievement of equality, legislative and other measures designed to protect or advance persons or categories of persons, disadvantaged by unfair discrimination may be taken.”

This provision therefore illustrates the right to equality's interconnection to other fundamental rights, as well as the Constitution's commitment to substantive equality, as opposed to formal equality. For example, while formal equality is focused on treating people the same, regardless of difference, substantive equality is concerned with taking differences into account so as to achieve equality of outcome.<sup>34</sup> Sections 9(3) and 9(4) go on to prohibit unfair discrimination by the state and by private individuals respectively. Section 9(3) specifically provides a list of grounds of discrimination which includes gender, race, sex and social origin, while section 9(5) specifically states that discrimination on any of these listed grounds is presumed to be unfair discrimination. The Constitution also includes the rights to human dignity (section 10), life (section 11) and freedom and security of the person (section 12).

In relation to health care, section 24(a) provides for the services that are necessary for an environment that is not harmful to one's health. Of particular importance, however, is section 27(1)(a) which states that everyone has the right to have access to health care services, including reproductive health care. Section 27(2) goes on to state that “reason-

able measures” must be taken to achieve the progressive realisation of this right “within available resources.” Section 27(3) does, however, state that no one may be refused emergency medical treatment. In relation to the interpretation of the Constitution, section 39(1)(a) mandates that, when interpreting the Bill of Rights, a court must promote the values that underlie an open and democratic society based on human dignity, equality and freedom. Section 39(1)(a) thus emphasises the interpretive importance of the value of equality when giving substantive content to the socio-economic rights. Section 195 of the Constitution further requires that public administration be governed by democratic principles while being responsive to people’s needs.

#### *b) Relevant Constitutional Jurisprudence*

##### *(i) Equality Jurisprudence*

Given the need to develop the interrelationship between the right to equality and the right to have access to health care services, it is necessary to analyse the extent to which the Constitutional Court has given effect to the principles underlying substantive equality. In *Harksen v Lane NO and Others*,<sup>35</sup> the Constitutional Court of South Africa (the Court) developed a detailed test to determine whether a complainant has suffered unfair discrimination in terms of section 9 of the Constitution. The first enquiry is whether an impugned provision differentiates between people or groups of people. In evaluating this differentiation, one must determine whether there is a legitimate government purpose, rationally connected to this differentiation. If there is not, then the provision fails the test. If there is a rational connection, one must then determine whether the differentiation in fact amounts to discrimination.<sup>36</sup> If the differentiation is based on a listed ground as set

out in section 9(3) of the Constitution, then it is presumed to be discrimination. If, however, it is not based on a listed ground, then one needs to determine whether the differentiation is based on a characteristic capable of impairing the human dignity of the claimant. This is when the court considers the historical and current social context of the complainant. Even if the answer is in the affirmative, the court still needs to determine if this discrimination is indeed unfair. If the discrimination is based on a listed ground as set out in section 9(3), then it is presumed to be unfair. If it is not, then the court needs to ask if the discrimination entrenches existing patterns of disadvantage. This is when the Court looks at the impact of the legal provision on the complainant, as well as the need for a positive recognition of difference. Even if it is found that the discrimination is unfair, it is still possible for the state to try and justify the provision or practice in terms of section 36 of the Constitution. This section provides that a right in the Bill of Rights may be limited by a law of general application, provided that the limitation is reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom.<sup>37</sup> This is when the court must consider the transformative values of the Constitution. The court therefore needs to consider whether the provision gives effect to restitution and ultimately the transformative aspirations of section 9(2) of the Constitution. Many subsequent interpretations of this test have unfortunately conflated considerations of human dignity and equality when analysing the impact of legal provisions.<sup>38</sup> This is problematic as this approach effectively ignores the socio-economic (material) dimensions of deprivation and how this influences one’s feasible options. It therefore also disregards the role the law can play in broadening these choices. Certain equality decisions have also simply broadened social inclusion

while failing to dislodge the underlying conditions that promote inequality.<sup>39</sup> The need to address the intersection between socio-economic deprivation and gender equality is effectively illustrated through the decision in *S v Jordan*<sup>40</sup> (*Jordan*). In this case, the appellants admitted in the Magistrate's Court that they had contravened the Sexual Offences Act 23 of 1957, which criminalises the selling of sex and brothel-keeping. The applicants claimed that the relevant provisions were unconstitutional, however, as they only criminalised sex workers and not their clients. The Court therefore had to consider whether section 20(1)(a) of the Act was discriminatory towards women. The majority held that this provision was not discriminatory, as the provision criminalised both male and female sex workers.<sup>41</sup> This apparently rendered its impact "gender-neutral".<sup>42</sup> The Court also went on to state that gender was not a differentiating factor in relation to sex work.<sup>43</sup> These statements are however clearly disconnected from the social context within which the law is operating in that the majority of sex workers are in fact female.<sup>44</sup> The majority of these women are also socio-economically vulnerable, often turning to sex work out of necessity, something which the minority judgment was able to recognise.<sup>45</sup> While both male and female sex workers require adequate health care services, women remain disproportionately affected by violence and harassment, as well as HIV/AIDS and STDs.<sup>46</sup> Women also have specific reproductive health care needs, such as those relating to birth control, which need to be effectively addressed. Criminalising sex workers therefore effectively entrenches existing vulnerabilities in addition to unequal social relationships, all of which is blatantly contrary to the spirit of section 9(2) of the Constitution, which requires the promotion of substantive equality.

## (ii) Socio-Economic Jurisprudence

In relation to the socio-economic jurisprudence, many of these cases have been criticised for emphasising procedural criteria, in contrast to the substantive values and interests that the socio-economic rights are intended to protect.<sup>47</sup> Many decisions have also been criticised for failing to address the gendered barriers to accessing these rights.<sup>48</sup> While the socio-economic rights have both positive and negative duties, the Court has yet to provide a detailed account of what these positive obligations specifically entail. It has, however, adopted reasonableness review, which entails a context-sensitive evaluation of the reasonableness of a government programme, in fulfilling the state's positive obligations under the socio-economic rights. In terms of this approach, the Court conducts an inquiry into whether a government programme is flexible, coherent, comprehensive and capable of effectively realising the particular socio-economic right.<sup>49</sup> A further factor that determines the reasonableness of a government programme is the degree to which provision has been made for the most vulnerable members of our society.<sup>50</sup> It is submitted that the elements underlining substantive equality, including attention to context, impact and transformative values can be effectively streamlined into these criteria. It is further submitted that such an approach would give greater effect to the transformative potential of the socio-economic rights. An interrelated interpretation of the constitutional rights has furthermore been approved by the Court. For example, in the case of *Government of the Republic of South Africa v Grootboom and Others*,<sup>51</sup> the Court specifically stated that:

"The proposition that rights are interrelated and are all equally important is

not merely a theoretical postulate. The concept has immense human and practical significance in a society founded on human dignity, equality and freedom. It is fundamental to an evaluation of the reasonableness of state action that account be taken of the inherent dignity of human beings”.<sup>52</sup>

The Court has also pointed out that the realisation of the socio-economic rights is integral to the advancement of gender equality and the establishment of a society in which men and women are “equally able to achieve their full potential”.<sup>53</sup> However, in spite of this recognition and the feminisation of poverty,<sup>54</sup> women have largely been absent from the socio-economic rights cases.<sup>55</sup> While the right to have access to health care services for women was considered in *Minister of Health and Others v Treatment Action Campaign and Others*,<sup>56</sup> the Court’s interpretation of this right has been criticised for not being sufficiently gender-sensitive. In this case, the focus was on the government’s limited provision of the anti-retroviral drug (nevirapine) to particular research and training sites, despite its proven effectiveness in reducing intrapartum mother-to-child transmission of the HIV/AIDS virus. The drug was also provided for free to the government, highlighting the unreasonableness of the state’s actions. Ultimately, the Court found the state’s limited and inflexible programme did not comply with its obligations under sections 27(1) and 27(2) of the Constitution. While the robust application of reasonableness review within this case has to be commended, the Court has been criticised for interpreting the right to have access to health care services primarily within the context of pregnancy and motherhood.<sup>57</sup> For example, the Court specifically stated that consideration needed to be given to the fact that the case concerned the lives of new-born babies who might be

saved by the administration of nevirapine to mother and child at the time of birth.<sup>58</sup> This is problematic as this approach perpetuates the stereotypical notion that women are only child-bearers and nurturers, while failing to develop a more nuanced understanding of the intersecting axes of gender, race and class.<sup>59</sup> This further perpetuated the traditional approach that the health care needs of women become secondary, while their caregiving role retains primary importance.<sup>60</sup> While the reality of caregiving and its impact on gender equality needs to be recognised, it needs to be done in a way that also recognises women as an end in their own right. In contrast, the Court’s approach contributed to the invisibility of women’s broader health care needs.

### c) *The National Legislative Framework Governing Health Care Services for SGBV*

Over the years the state has enacted numerous pieces of legislation in seeking to provide health care services to abused women. However, in spite of certain progressive provisions, numerous forms of GBV are currently neglected by the state, such as corrective rapes, human trafficking and stalking. The current legislative framework is also plagued by implementation challenges and critical gaps. For example, despite the Domestic Violence Act 116 of 1998 (DVA) recognising that domestic violence is a serious social evil, and that the victims of domestic violence are among the most vulnerable members of our society,<sup>61</sup> the DVA is notably silent as to the role of the Department of Health. This is somewhat surprising given that the DVA places specific responsibilities on police personnel to assist complainants of domestic violence.<sup>62</sup> While the DVA does also provide a nuanced and detailed description of domestic violence,<sup>63</sup> it fails to provide any refer-

ence to the provision of health care services for survivors of this violence. This omission is problematic as health care workers are often ideally situated to identify domestic violence. Research has also indicated that the health sector is the first and most frequently utilised sector by abused women.<sup>64</sup> While the DVA does specifically mandate that the Police Services assist complainants in obtaining medical treatment (section 2(a) of the DVA), the criminal case of *S v Engelbrecht*<sup>65</sup> revealed the practical challenges of implementing such measures. In *Engelbrecht*, evidence that was presented before the court revealed that when Mrs Engelbrecht had phoned the emergency services the police dispatchers had argued with her about why they were not going to assist her. Furthermore, despite the detailed provisions of section 2(a) of the DVA, many police officials do not believe that it is their responsibility to escort complainants to health care facilities. As further pointed out by Bonita Meyersfeld, this apathy effectively exacerbates the normalisation of GBV.<sup>66</sup> This therefore reveals that while the DVA needs to be praised for its many progressive provisions, these innovative aspects will remain ineffective without an enabling environment to facilitate implementation.<sup>67</sup> In this regard, positive duties need to be placed on health care providers to assist survivors of domestic violence in a humane manner. Police personnel and health care workers also need to be adequately trained, while a system of accountability needs to be introduced and effectively managed.

In 2004, the National Health Act (NHA) 61 of 2003 was introduced to give effect to the White Paper for the transformation of the South African health care system. Section 2(a) of the NHA specifically states that its purpose is to create unified services while protecting and promoting the rights of vulnerable groups, including women and chil-

dren. However, in spite of these provisions, the NHA fails to mention rape, domestic violence or GBV anywhere within its provisions. In contrast, the primary focus of the NHA is on maternal health care services and on the termination of pregnancies. While these services are necessary and admirable, they have not been adequately implemented by the state. These services are, furthermore, insufficiently responsive to the broader health care needs of women in South Africa. For example, the NHA fails to acknowledge cervical and breast cancer, despite the fact that more women are dying from cervical cancer than maternal mortality.<sup>68</sup> The broader health care needs of women, such as services relating to screening for cervical cancer or services for SGBV are thus effectively “missing” from this piece of health care legislation.

The Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007 (SOA), aims to afford complainants of sexual offences, “the maximum and least traumatising protection that the law can provide”.<sup>69</sup> However the SOA contains unnecessary obstacles to the provision of PEP and does not contain a broader section relating to the general health care management of rape survivors. For example, section 28(1)(a)(i) of the SOA states that a rape survivor exposed to the risk of HIV “may” receive PEP, subject to the condition that the rape survivor lays a charge with the South African Police Services (section 28(2)(a)) or reports an incident in respect of an alleged sexual offence in the “prescribed manner” at a “designated health establishment” (section 28(2)(b)). This is problematic as there are numerous reasons as to why a complainant may be afraid or reluctant to report such an offence and the provision of services should not be limited as a result of the devastating nature of sexual offences. The focus within the SOA is also narrowly placed on the provision of

PEP and HIV/AIDS services, ignoring the emotional and psychological needs of rape survivors. It is submitted that the removal of section 28(2) is necessary as rape has reached extreme levels within South Africa, while effectively intersecting with, and compounding the HIV/AIDS epidemic. It is also necessitated by the fact that section 28 primarily concerns women who cannot afford to pay for medical services. Limiting PEP thus ultimately entrenches the disadvantage predominantly experienced by poor black women. As pointed out by the Court in the case of *Minister of Health v Treatment Action Campaign*,<sup>70</sup> when drafting health care legislation and policy, the state needs to take into account the differences between those who can afford to pay for services and those who cannot.<sup>71</sup>

#### d) Relevant Policy

The policy paper on National Health Insurance (NHI), which is to be funded through a compulsory taxing system and an insurance scheme, seeks to give effect to section 27 (1) (a) of the Constitution. It attempts to do this by ensuring that all South Africans will have access to a defined comprehensive package of appropriate and quality health care services, regardless of their socio-economic status.<sup>72</sup> The policy paper also states that the underlying principles intended to govern the NHI system include free access to health care services, social solidarity, effectiveness, appropriateness, equity, affordability and efficiency.<sup>73</sup> While the policy paper does briefly refer to violence against women, it does not adopt any practical strategies on how the state intends to address this epidemic. There is also an insufficient focus on improving the quality of existing services for survivors of rape and domestic violence. This is in spite of the recognition in both the National Strategic Plan and the policy paper on the NHI system

that violence forms part of the quadruple burden of disease currently ailing South Africa. Therefore, while the NHI system does have the potential to improve equal access to health care services for women, the specific needs of women should be further integrated into the NHI policy document.

The 365 Day National Action Plan to end Gender Violence of 2007<sup>74</sup> does contain certain progressive health care goals, such as the increased training of health care providers, as well as the need to implement the National Sexual Assault Policy (NSAP).<sup>75</sup> However, in spite of these provisions, implementation of the NSAP remains erratic and slow. For example, the NSAP states, under its guiding principles, that health care services should be provided in a non-judgmental manner and that services should always be provided by specialists. However, services for survivors of rape are offered in a variety of settings, from district, regional and tertiary-level hospitals, with health care providers often unable to provide specialised care.<sup>76</sup> Rape survivors are also often bypassed by patients who are more severely physically injured, while being exposed to a stressful environment. There are also persistent complaints that health care workers are judgemental and abusive.<sup>77</sup> Furthermore, the 365 Day National Action Plan only briefly refers to its commitment to the socio-economic rights without further recognising their particular importance for women and how they can effectively empower abused women.

Compounding these problems is the fact that South Africa's health care system is currently in a state of crisis. For example, the public health care system is severely under-staffed and under-resourced despite the fact that it is currently catering for the majority of South Africans. Research conducted by the South African Human Rights Commission has fur-

ther described this system as “lamentable”, with problems including an inadequate infrastructure, limited or non-existent transport, long waiting hours and the discriminatory attitudes of overworked and desensitised staff members.<sup>78</sup> While the legacy of apartheid still haunts the South African health care system today, corruption is also undermining the system. This is illustrated through a report by Section 27 (a public interest law centre) which highlighted that over a period of 18 months from January 2009, more than R800 million was stolen from the public health sector by public officials.<sup>79</sup> It is no wonder then that the health care system has been described as a democratic failure.<sup>80</sup>

This effectively reveals that the state is currently neglecting many of the most urgent health care needs of SGBV, as well as the health care needs of the poor. Given the extreme levels of GBV, infusing health care services with the principles underlying substantive equality is therefore necessary in order to transform systemic gender inequality in South Africa and to affirm the inherent value of all South Africans. Engendering health care services is also essential,<sup>81</sup> as, while the devastating health consequences of GBV cannot be prevented completely, many of these consequences could be ameliorated by a comprehensive and multi-dimensional health care response.<sup>82</sup> Quality health care interventions can also reduce the potential for disability and can help women to cope with the impact of violence in their lives.<sup>83</sup>

#### **4. Developing an Appropriate Health Care Response to GBV**

##### *a) Developing The Jurisprudence – Interpretive Interdependence*

It is submitted that an interrelated interpretation between the right to equality and

socio-economic rights can assist in ensuring that the contextual analysis in unfair discrimination cases is more responsive to the socio-economic deprivation experienced by the applicant. A form of related interpretation known as “interpretative interdependence” between these rights has also been specifically advocated for by Sandra Liebenberg and Beth Goldblatt.<sup>84</sup> In terms of this approach, the two rights are treated as separate but complementary, with one effectively considering how the values and purposes underpinning one right (for example, equality) may be relevant and useful to the development of the jurisprudence on the other right (such as the right of access to health care services).

In accordance with this approach, integrating the material (socio-economic) interests of complainants could effectively shift the focus of equality jurisprudence back onto group-based understandings of material disadvantage, ultimately preventing the disproportionate focus on dignity.<sup>85</sup> Adding considerations of material disadvantage to the analysis would also reveal the manner in which poverty exacerbates gender inequality. Equality arguments can further take account of socio-economic rights as tools to redress issues of material disadvantage based on discrimination and status. For example, providing access to adequate shelter for abused women would go a long way to broadening their feasible options, while protecting them from violence.<sup>86</sup> The strong correlation between status inequality and poverty therefore means that the right of everyone to access socio-economic goods can positively reinforce the redistributive dimension of section 9(2). This interrelationship has the additional potential to recognise particular needs while preventing the “levelling down” of services in the name of equality. For example, while equality can be used to justify treating people equally badly,

socio-economic rights call for the progressive realisation of these rights. In addition, when individuals or groups are deprived of existing access to socio-economic goods, this is perceived as negative infringements on the socio-economic rights. This infringement then requires justification in terms of section 36 of the Constitution, which requires that the infringement must be based on a law of general application and justifiable in light of the constitutional vision of a society based on human dignity, equality and freedom.<sup>87</sup> It is submitted that an interrelated interpretation between the right to equality and the socio-economic rights can also inform the development of health care legislation and policy, so as to be more responsive to the specific needs and experiences of women.

#### *b) Developing Health Legislation and Policy*

In relation to existing legislation, the DVA and the SOA could be amended to place positive duties on health care providers to provide quality and humane health care services to SGBV. It is also imperative that neglected forms of GBV, such as corrective rapes, are specifically addressed by the state. It is further necessary to improve implementation of the NHA, while the proposed NHI system needs to be reviewed so as to be infused with women's particular health care needs. This can be complemented by the improvement of the existing infrastructure so as to facilitate increased privacy and protection for SGBV. Health care providers will also need to be adequately trained if the state is to address the deeply entrenched social and cultural beliefs that justify the ill-treatment of women. In this regard infusing health care services with a substantive equality perspective may assist health care providers in understanding that a woman's health and choices are often shaped by wider social, economic and political relations. Legislation and policy should

therefore guide health care providers on how to recognise and adequately respond to the nature of GBV in a manner that respects the dignity, autonomy and agency of women.

In terms of policy, it is submitted that in order to infuse the right to have access to health care services with the right to equality, the Department of Health needs to develop a comprehensive national programme on GBV, with a particular focus on advancing the rights of women. This programme needs to recognise the full extent of GBV and its devastating impact on women. It also needs to positively recognise the specific needs and experiences of women, as well as the different forms of GBV. The programme also needs to effectively transform gendered relations within our society through redistributive measures, extensive training and education.

In December 2012, the Minister of Women, Children and People with Disabilities, Lulu Xingwana, announced the establishment of the Council for Gender-Based Violence, which, according to the Minister, will take the war against GBV to a higher level while monitoring progress on initiatives aimed at addressing GBV.<sup>88</sup> The Council is also tasked with implementing the 365 Day Action Plan on GBV. The Council has however been worryingly quiet over the past few months. While the 2014 National Plan of Action on GBV is currently being developed by the Council, it has not yet been released, despite plans to finalise it in December 2013. It is submitted that this plan could however be utilised to effectively recognise the historical and current social context of entrenched gender inequality within South Africa and how it manifests into various forms of GBV, including previously neglected forms of violence. The state can also set out its specific strategies to improve socio-economic services so as to alleviate the devastating consequences of such violence,

while effectively protecting women. The programme will also need to engage men and boys while encouraging women to demand more from men and to recognise their own worth.<sup>89</sup> In this regard, recognising women's specific needs and empowering them socio-economically has the powerful potential to shift understandings of gender within our society, as well as gendered power relations. It is therefore submitted that the National Council has the opportunity, and the responsibility, to recognise and cultivate the inter-relationship between the socio-economic rights and substantive gender equality in developing its Action Plan.

### *c) Allocating the Necessary Resources*

Simultaneously, the state needs to develop a comprehensive information system in order to generate and collect gender-disaggregated data on the prevalence and consequences of GBV. Such information then needs to be publicised so as to empower abused women and health care providers. It is also clear that such measures will need to be coupled with budgetary allocations. While the South African public health care system is facing various crises, the health care needs of abused women cannot simply be ignored. This is due to the extremely high prevalence of GBV, its devastating health consequences, and the Court's affirmation that the needs of the most vulnerable members of our society cannot be neglected within government policy.<sup>90</sup> In order to facilitate women's participation in shaping health care services, the state will also need to be more transparent in relation to such budgetary allocations.

## **5. Conclusion**

It is thus clear that despite the extreme levels of GBV in South Africa, we are not powerless to address it. In contrast, positive measures

are specifically needed (and constitutionally mandated) in order to shift South Africa's gendered political and social institutions in a direction that effectively fosters substantive gender equality. In terms of interpreting the constitutional rights, substantive equality can effectively serve as a tool to enhance the power of socio-economic rights through recognising the specific challenges facing many women while requiring the redistribution of socio-economic goods to compensate for this disadvantage. By interpreting the socio-economic rights and the right to equality substantively and as mutually reinforcing, judicial interpretations of these rights will therefore be more responsive to the intersecting axes of poverty and inequality.

The legislature and the executive also have a crucial responsibility to develop effective legislative and policy responses to the particular health care needs of SGBV. By facilitating the participation of abused women in shaping such health care responses to GBV, the law can be used to articulate the experiences of abused women and to contribute to the social change that needs to occur. Furthermore, by grounding such services in the lived reality of abused women's lives, the law is able to provide remedies that are more responsive to the needs and experiences of SGBV. The provision of quality health care services, such as effective counselling, can further serve to prevent the escalation of domestic violence, while improving adherence to PEP. Simultaneously, by improving access to PEP, the state can effectively prevent the spread of HIV/AIDS. Sufficient psychological health care services can further empower abused women to effectively deal with the consequences of GBV within their lives.<sup>91</sup>

The state is thus called upon to take the necessary steps to recognise all forms of GBV and to provide adequate and timely access to

quality health care services for SGBV. A more proactive response is further necessary as research has revealed that more women are killed in this routine “gendercide” in any one decade than people were slaughtered in all the genocides of the twentieth century.<sup>92</sup> In order to protect the constitutional rights of abused women, it is thus imperative that all law-makers in South Africa take the intersection between the constitutional commitment to gender equality and the right of access to health care services seriously.

- 
- 1 Tarryn Bannister is a doctoral candidate at the Socio-Economic Rights and Administrative Justice Research Project (<http://www.sun.ac.za/seraj>) at Stellenbosch University. This article is based on his 2012 LLM thesis titled: “The right to have access to health care service for survivors of gender-based violence”. Thank you to Professor Sandra Liebenberg for reading an earlier draft of this paper.
  - 2 Within the South African Women Empowerment and Gender Equality Bill of 2012, GBV is defined as “[a]ll acts perpetrated against women, men, girls and boys on the basis of their gender which cause or could cause them physical, sexual, psychological, emotional or economic harm and includes threats to do so.” See Department of Women, Children and People with Disabilities, *Women Empowerment and Equality Draft Bill*, 2013, available at: <http://www.info.gov.za/view/DownloadFileAction?id=173252>.
  - 3 United Nations Population Fund, *State of the World Population 2005: The Promise of Equality: Gender Equity, Reproductive Health and the Millennium Development Goals*, 2005, 30 January 2014, available at: [https://www.unfpa.org/swp/2005/pdf/en\\_swp05.pdf](https://www.unfpa.org/swp/2005/pdf/en_swp05.pdf).
  - 4 Kristof, N. and Wudunn, S., *Half the Sky: How to Change the World*, Virago Press, 2010, p. xviii.
  - 5 Meyersfeld, B., *Domestic Violence and International Law*, Hart Publishers, 2011, p. xxxv.
  - 6 Abrahams, N., Mathews, S., Jewkes, R., Martin, L.J. and Lombard, C., “Every Eight Hours: Intimate femicide in South Africa 10 years later!”, *Medical Research Council Policy Brief*, Vol. 5, 2012, 18 December 2013, available at: <http://www.mrc.ac.za/policybriefs/everyeighthours.pdf>.
  - 7 *Ibid.*
  - 8 South African Police Services, “Crime Statistics Overview RSA 2012-2013”, 23 January 2014, available at: [http://www.saps.gov.za/statistics/reports/crimestats/2013/downloads/crime\\_statistics\\_presentation.pdf](http://www.saps.gov.za/statistics/reports/crimestats/2013/downloads/crime_statistics_presentation.pdf).
  - 9 Roehrs, S., “Half-hearted HIV Related Services for Victims”, in *Should We Consent?: Rape Law Reform in South Africa*, (eds.) Artz, L. and Smythe, D., Juta, 2008, p. 175.
  - 10 Section 9(2) of the Constitution of the Republic of South Africa, 1996 (the Constitution).
  - 11 Section 12(1)(c) of the Constitution.
  - 12 Sections 26, 27 and 28 of the Constitution.
  - 13 International Federation for Human Rights, *Montreal Principles on Women’s Economic, Social and Cultural Rights*, 2002, 15 December 2013, available at: <http://www.escr-net.org/docs/i/426624>.
  - 14 Section 27(1)(a) of the Constitution.
  - 15 See Budlender, D., “Women and Poverty”, *Agenda*, Vol. 64, 2005, pp. 30-35 where she points out that: “While there are many different ways of measuring poverty, all suggest that women are more likely than men to live in poverty. This statement holds, whether we measure poverty simply by income, or use wider measures which encompass other aspects.”
  - 16 Albertyn, C. and Goldblatt, B., “Equality in the Final Constitution”, in *Constitutional Law of South Africa*, (eds.) Woolman, S., Roux, T. and Bishop, M., Juta, 2008, p. 35.
  - 17 Joyner, K., *Health Care for Intimate Partner Violence: Current Standards of Care and Development of Protocol Management*, DPhil Thesis at University of Stellenbosch, 2009, p. 59: “Women appear to become trapped in a cyclical pattern of IPV, with brief moments within the cycle when they are more likely to seek help, which creates windows of opportunity for intervention.”; Mercy, J., Butchart, A., Rosenberg, M., Dahlberg, L., and Harvey, A., “Preventing Violence in Developing Countries: A Framework for Action”, *International Journal of Injury Con-*

- trol and Safety Promotion*, Vol. 15, 2008, p. 15-199.
- 18 See above, note 6.
  - 19 See above, note 3.
  - 20 *Ibid.*
  - 21 Seedat, M., Van Niekerk, A., Jewkes, R., Suffla, S. and Ratele, K., "Violence and Injuries in South Africa: Prioritising an Agenda for Prevention", *The Lancet*, Vol. 374, 2009, p. 1011; See also above note 9, p.1.
  - 22 Heise, L. and Garcia-Moreno, C., "Violence by Intimate Partners", in *World Report on Violence and Health*, (eds.) Etienne, G., Krug, L., Dahlberg, J., Anthony, A.M., Zwi, B. and Lozano, R., World Health Organization, 2002, 30 January 2014, available at: [http://whqlibdoc.who.int/publications/2002/9241545615\\_chap4\\_eng.pdf](http://whqlibdoc.who.int/publications/2002/9241545615_chap4_eng.pdf).
  - 23 World Health Organization, *Violence against Women Fact Sheet No 239*, 2009, 30 January 2014, available at: <http://www.who.int/mediacentre/factsheets/fs239/en/index.html>; See also above note 18.
  - 24 Meyersfeld, B., "Domestic Violence, Health, and International Law", *Emory International Law Review*, Vol. 22, 2008, pp. 61-112.
  - 25 See World Health Organization, above note 23; See also Heise, above note 22, p. 100.
  - 26 Coker, A., Hopenhayn, C., DeSimone, C., Bush, H. and Crofford, L., "Violence against Women Raises Risk of Cervical Cancer", *Journal of Women's Health*, Vol.18, 2009, p. 1179.
  - 27 Chisala, S., "Rape and HIV/AIDS: Who's Protecting Whom?", in *Should We Consent?: Rape Law Reform in South Africa*, (eds.) Artz, L. and Smythe, D., Juta, 2008, p. 55. Chisala observes that this biological vulnerability is a result of the fact that semen carries a high viral load, and because of the physiological nature of the vagina which has a large mucosal area.
  - 28 As pointed out by the Constitutional Court in *President of the Republic of South Africa v Hugo* 1997 4 SA 1 (CC); 1997 6 BCLR 708, Para 38: "The result of being responsible for children makes it more difficult for women to compete in the labour market and is one of the causes of the deep inequalities experienced by women in employment. The generalisation upon which the President relied is therefore a fact which is one of the root causes of women's inequality in our society."
  - 29 See above, note 17, pp. 178-179. "In a climate of coercion and violence by men, women's capacity to resist behaviours which increase the risk of contracting HIV is compromised, so IPV has a knock-on effect for other health issues (...) [f]orced to choose between the immediate threat of violence and the possibility of HIV infection, women frequently resigned themselves to the sexual demands and indiscretions that might increase their risk of HIV acquisition". See also: Chant, S., "Re-thinking the Feminisation of Poverty in regard to Aggregate Gender Indices", *Journal of Human Development Promotion*, Vol. 7, 2006, p. 206: "Household income may bear no relation to women's poverty because women may not necessarily be able to access it"
  - 30 See World Health Organization, above note 23; See Heise, above note 22, p. 100.
  - 31 See Joyner, above note 17, p. 103.
  - 32 Artz, L. and Smyth, D., "Introduction: Should We Consent?", in *Should We Consent?: Rape Law Reform in South Africa*, (eds.) Artz, L. and Smythe, D., Juta, 2008, p. 15.
  - 33 Preamble to the Constitution.
  - 34 Currie, I. and De Waal, J., *The Bill of Rights Handbook*, Juta, 2005, p. 232.
  - 35 1997 11 BCLR 1489 (CC); 1998 1 SA 300 (CC).
  - 36 See above, note 34, p. 243-245; Discrimination is defined as differential treatment on illegitimate grounds. Differentiation based on a listed ground mentioned in section 9(3) is presumed to be unfair discrimination. The Court has also recognised analogous grounds not listed in section 9(3), including HIV/AIDS in *Hoffman v South African Airways* 2001 1 SA 1 (CC); 2000 11 BCLR 1235 (CC). If such differentiation is not based on a listed ground then the applicant must prove that it is unfair discrimination. Currie and De Waal describe unfair discrimination as discrimination that entrenches existing inequality.
  - 37 See above, note 34.
  - 38 Cathi Albertyn has pointed out that the conflation of dignity and equality is problematic in that dignity is then often prioritised, while the purpose of remedying disadvantage is ultimately suppressed. See Albertyn, C., "The Stubborn Persistence of Patriarchy? Gender Equality and Cultural Diversity in South Africa", *Constitutional Court Review*, Vol. 2, 2009, pp. 165-185.

- 39 Albertyn, C., "Substantive Equality and Transformation in South Africa", *South African Journal on Human Rights*, Vol. 23, 2007, pp. 253-254.
- 40 *S v Jordan (Sex Workers Education & Advocacy Task Force as Amicus Curiae)* 2002 6 SA 642 (CC); 2002 11 BCLR 1117 (CC).
- 41 *Ibid.*, Para 9.
- 42 *Ibid.*
- 43 *Ibid.*, Para 15.
- 44 Simpson, J., "Stereotyping Sex Workers: *S v Jordan and others*", Paper Submitted to the 2009 John and Mary Yaremko Forum on Multiculturalism and Human Rights: Student Symposium on Women's Human Rights, available at: [http://www.law-lib.utoronto.ca/diana/2009\\_symposium\\_papers/simpson\\_paper.pdf](http://www.law-lib.utoronto.ca/diana/2009_symposium_papers/simpson_paper.pdf) (last accessed 30 January 2014).
- 45 See above, note 40, Para 68: "The evidence suggests that many women turn to prostitution because of dire financial need and that they use their earnings to support their families and pay for their children's food and education."
- 46 *Ibid.*, Para 87. Counsel for the applicant specifically pointed out that the marginalisation of sex workers by the law renders these women vulnerable to violence as they are forced to work in isolated circumstances and because they fear reporting assaults to the police.
- 47 Brand, D., "What are Socio-Economic Rights for?" in *Rights and Democracy in a Transformative Constitution*, (eds.) Botha, H., Van der Walt, A. and Van der Walt, J., Juta, 2004, pp. 33-36; Pieterse, M., "Coming to Terms with Judicial Enforcement of Socio-Economic Rights", *South African Journal on Human Rights*, Vol. 20, 2007, pp. 383-410; Liebenberg, S., *Socio-economic Rights: Adjudication under a Transformative Constitution*, Juta, 2010, pp. 175-176.
- 48 Albertyn, C., "Gendered Transformation in South African Jurisprudence: Poor Women and the Constitutional Court", *Stellenbosch Law Review*, Vol. 22, 2012, pp. 591-600.
- 49 *Government of the Republic of South Africa v Grootboom* 2001 1 SA 46 (CC); 2000 11 BCLR 1169 (CC), Paras 40-46.
- 50 *Ibid.*, Para 44.
- 51 *Ibid.*
- 52 *Ibid.*, Para 83.
- 53 *Ibid.*, Para 23.
- 54 See above, note 15.
- 55 Cathi Albertyn points out that women have been effectively "missing" in all socio-economic rights cases so far (except for *Minister of Health v TAC*). See above, note 48, p. 599.
- 56 *Minister of Health and Others v Treatment Action Campaign and Others* (No 2) 2002 5 SA 721 (CC); 2002 10 BCLR 1033 (CC).
- 57 See above, note 48, p. 591.
- 58 See above, note 56, Para 72.
- 59 See above, note 48, pp. 591-603.
- 60 *Ibid.*
- 61 Preamble to the Domestic Violence Act 116 of 1998.
- 62 Section 2 of the Domestic Violence Act 116 of 1998.
- 63 Section 1 of the Domestic Violence Act 116 of 1998.
- 64 Parenzee, P., Artz, L. and Moul, K., *Monitoring the Implementation of the Domestic Violence Act: First Research Report 2000-2001*, 2001, available at: <http://www.ghjru.uct.ac.za/osf-reports/dva-report.pdf> (last accessed 30 January 2014).
- 65 2005 2 SACR 41 (W).
- 66 See Meyersfeld, above note 24, p. 191.
- 67 Bannister, T., *The right to have access to health care services for survivors of gender-based violence*, LLM Thesis at University of Stellenbosch, 2012, p. 74.

- 68 Mthembu, S., “Cervical Cancer and Women Living with HIV in South Africa: Failure of AIDS Treatment Policy or Gendered Exclusions in Health Care?”, *Agenda*, Vol. 92, 2012, pp. 35-36.
- 69 Section 2 of the SOA.
- 70 See above, note 56.
- 71 *Ibid.*, Para 70.
- 72 Department of Health, *National Health Insurance in South Africa Policy Paper*, 2011, p. 16, available at: <http://www.info.gov.za/view/DownloadFileAction?id=148470>.
- 73 *Ibid.*, p. 16.
- 74 *365 Day National Action Plan to End Gender Violence*, 2007, available at: <http://www.info.gov.za/view/DownloadFileAction?id=72515> (last accessed 20 December 2013).
- 75 Department of Health, *National Sexual Assault Policy*, 2005, available at: <http://webapps01.un.org/vawdatabase/uploads/National%20Sexual%20Assault%20Policy%20-%202005.pdf> (last accessed 30 January 2014).
- 76 Vetten, L. and Jacobs, T., “Towards Developing and Strengthening a Comprehensive Response to the Health Care Needs of Rape Survivors”, 2008, available at: <http://www.tlac.org.za/wp-content/uploads/2012/01/developing-and-strengthening-a-comprehensive-response-to-the-health-care-needs-of-rape-survivors.pdf> (last accessed 30 January 2014).
- 77 See above, note 75.
- 78 South African Human Rights Commission, “Public Inquiry: Access to Health Care Services”, 2007, Vol. 1, p. 7, available at: <http://www.info.gov.za/view/DownloadFileAction?id=99769> (last accessed 30 January 2014).
- 79 Eagar, D., “When the Solution Compounds the Problem”, in *Death and Dying in the Eastern Cape: An Investigation into the Collapse of a Health System*, Section 27, 2013, available at: <http://www.section27.org.za/wp-content/uploads/2013/09/SECTION27-report-redacted.pdf>.
- 80 Heywood, M., “Health Warning”, in *Death and Dying in the Eastern Cape: An Investigation into the Collapse of a Health System*, Section 27, 2013, available at: <http://www.section27.org.za/wp-content/uploads/2013/09/SECTION27-report-redacted.pdf> (last accessed 20 December 2013).
- 81 Fredman, S., “Engendering Socio-Economic Rights”, *South African Journal on Human Rights*, Vol. 25, 2009, p. 411.
- 82 See above, note 67, p.135.
- 83 Mercy, J., Butchart, A., Rosenberg, M., Dahlberg, L. and Harvey, A., “Preventing Violence in Developing Countries: A Framework for Action”, *International Journal of Injury Control and Safety Promotion*, Vol. 15, 2008, pp. 197-199.
- 84 Liebenberg, S. and Goldblatt, B., “The Interrelationship between Equality and Socio-Economic Rights under South Africa’s Transformative Constitution”, *South African Journal on Human Rights*, Vol. 23, 2007, pp. 335-335.
- 85 Albertyn, C. and Goldblatt, B., “Facing the Challenge of Transformation: Difficulties in the Development of an Indigenous Jurisprudence of Equality”, *South African Journal on Human Rights*, Vol.14, 1998, pp. 248- 257.
- 86 Combrinck, H., “Living in Security, Peace and Dignity: The right to have access to housing of women who are victims of gender-based violence”, *Community Law Centre*, 2009, available at: [http://www.communitylawcentre.org.za/news/news\\_item.2009-08-06.3574532301](http://www.communitylawcentre.org.za/news/news_item.2009-08-06.3574532301) (last accessed 20 December 2013).
- 87 See above, note 67, pp. 17-18.
- 88 Xingwana, L., *Statement by the Minister of Women, Children and People with Disabilities, Ms Lulu Xingwana during Cabinet media briefing on the launch of the National Council Against Gender-Based Violence*, 2012, available at: <http://www.info.gov.za/speech/DynamicAction?pageid=461&tid=80830> (last accessed 15 December 2013).
- 89 Gould, C., *On the record: Professor Rachael Jewkes*, 2013, available online at: <http://www.issafrica.org/uploads/SACQ43Record.pdf> (last accessed December 2013).
- 90 See above, note 56, Para 44.
- 91 See above note 67, p. 178.
- 92 See above, note 4, p. xviii.