**Ref: MM/MP/CM**

14 August 2015

UN Working Group on the issue of

Discrimination against Women in Law and in practice

Office of the United Nations High Commissioner for Human Rights

Geneva

**BY EMAIL**: [**wgdiscriminationwomen@ohchr.org**](mailto:wgdiscriminationwomen@ohchr.org)

**RE: Call for submission - Good practices in the elimination of discrimination against women with regard to the right to health and safety**

1. We refer to your call for comment on the Good practices in the elimination of discrimination against women with regard to the right to health and safety.
2. We hereby humbly submit our submissions on the topic above. We are grateful for, and welcome this opportunity to contribute to the development of good practices in the elimination of discrimination against women with regard to the right to health and safety.

**INTRODUCTION TO THE LEGAL RESOURCES CENTRE**

1. The Legal Resources Centre (hereinafter referred to as the “LRC”) is a public interest, non-profit law clinic in South Africa that was founded in 1979. The LRC has since its inception shown a commitment to work towards a fully democratic society underpinned by respect for the rule of law and constitutional democracy. The LRC uses the law as an instrument of justice to facilitate the vulnerable and marginalised to assert and develop their rights; promote gender and racial equality and oppose all forms of unfair discrimination; as well as to contribute to the development of human rights jurisprudence and to the social and economic transformation of society.
2. The LRC has since its inception in 1979 operated throughout South Africa from its offices situated in the cities of Johannesburg, Cape Town, Durban and Grahamstown.
3. The LRC, through its Equality and Non-Discrimination project (“the project”), focuses on empowering marginalised and vulnerable groups by utilising creative and effective solutions to achieve its aims. These include using a range of strategies including impact litigation, law reform initiatives, participation in development processes, education and networking within and outside of South Africa. Within the arena of equality and non-discrimination, the LRC has viewed the rights of vulnerable and marginalised persons including sexual minorities, women, children, refugees and sex workers as being integral to the pursuit of social justice. It is in this context that we seek to ensure that the existing legal apparatus available and in development are appropriately cognisant of the rights and realities of vulnerable and marginalised groups. We believe that this will ensure that their experiences of discrimination and prejudice are reduced and eventually diminished. Furthermore, we believe that the national, regional and international laws are collaboratively an instrumental tool in securing substantive equality for vulnerable individuals.
4. Through strategic litigation, the LRC has played a pivotal role instrumental in developing a strong jurisprudence for equality and non-discrimination.

**RESPONSES TO THE QUESTIONNAIRE**

1. **Prevention of sex discrimination in the enjoyment of the right to health and safety**
2. ***Health***
3. **Does your country have regulations (in the Constitution, legislation or in other legal codes) that guarantee:**

*(Please specify in the space provided for this purpose "yes" or "no")*

**(Yes)** the right to equal access for women and men to all forms of healthcare, at the highest available level, including access to alternative health provisions such as homeopathy, naturopathy, etc.

**(Yes)** access to sexual and reproductive health services

**(Yes)** women’s rights to make autonomous decisions regarding their sexual and reproductive lives

1. **Are medical services related to women’s sexual and reproductive life and/or violence against women covered by universal health coverage?**

**Yes** ( X ) No ( )

But the services are very specific and limited. Sexual Reproductive Health Rights form part of family planning services so do not necessarily appeal to adolescent girls, and violence against women’ s health services are focused on HIV/AIDS transmission with no provision for Psycho - social support needs.

**If yes, what kind of medical services are free of charge?**

* + Free antenatal, delivery and postnatal care and support for women, in the public sector
  + Free health care services available in the public sector to all children under the age of 6 years

**Are women’s rights to health, including sexual and reproductive health, autonomy and health insurance, applied also to girls under 18?**

**Yes**  ( X ) No ( )

* It is important to note however that sexual reproductive health and health insurance is available, but not necessarily structured in such a manner so as to apply to girls under 18 years. It is therefore not so much that the service is extended, but that girls are not purposefully excluded.

*If “yes”, please indicate the legislation regulating these and indicate enforcement mechanisms.*

* Choice on Termination of Pregnancy Act 92 of 1966 allowing a woman of any age to request and receive an abortion,
* The Promotion of Equality and Prevention of Unfair Discrimination Act 4 of 2000 defining sex discrimination as including gender-based violence and female genital mutilation;
* The Children’s Act 38 of 2005 recognizing the right of every female child under the age of 16 not to be subjected to genital mutilation.

1. **Are there any provisions which restrict women’s access to health services? In particular which:**

*(Please specify in the space provided for this purpose "yes" or "no")*

(**No**) require the consent of a male relative/husband for a married woman’s medical examination or treatment or access to contraceptives or abortion,

(**No**) require parental consent in case of adolescents’ access to contraceptives or abortion;

* The Choice on Termination of Pregnancy Act 92 of 1966 guarantees that abortion is available upon request in South Africa. The only consent that is required is the consent of the pregnant woman/girl. In the case of a pregnant minor, a medical practitioner or a registered midwife shall advise such minor to consult with her parents, guardian, family members or friends before the pregnancy is terminated provided that the termination of the pregnancy shall not be denied because such minor chooses not to consult them.
* The Constitution does not explicitly mention abortion; rather, two sections of the Bill of Rights mention reproductive rights, section 12(2)(a) and section 27(1)(a) . Women in South Africa have the legal right to use and access information about contraception, and to freely decide when and how many children to have.
* Section 134(1) of the Children’s Act states that no person may refuse to sell condoms to a child over the age of 12 years; or provide a child over the age of 12 years with condoms on request where condoms are provided or distributed free of charge.
* Section 134(2) of the Children’s Act states that contraceptives, other than condoms, may be provided to a child on request by the request of the child and without the consent of the parent or care-giver of the child if the child is at least 12 years of age; proper medical advice is given to the child; and a medical examination is carried out on the child to determine whether there are any medical reasons why a specific contraceptive should not be provided to the child.
* Section 134(3) of the Children’s Act notes that a child who obtains condoms, contraceptives or contraceptive advice is entitled to confidentiality in this respect except in cases where health professionals are obliged to report cases of physical or sexual abuse, or deliberate neglect of a child to the Department of Social Development, a designated child protection organisation or the police.
* In terms of section 10(1)(c) any person who prevents the lawful termination of a pregnancy or obstructs access to a facility for the termination of a pregnancy, shall be guilty of an offence and liable on conviction to a fine or to imprisonment for a period not exceeding 10 years.
* It should be noted that in South Africa, particularly in rural areas limited or lack of information on abortion rights under the Choice of Termination of Pregnancy Act and the poor quality of the designated facilities are the most significant barriers to access reproductive rights.[[1]](#footnote-1)
* Further, notwithstanding liberal abortion laws and previous reductions in maternal mortality attributable to unsafe abortion, South Africa continues to face serious problems with unsafe abortion and a relatively high rate of self-induction.[[2]](#footnote-2) “*SA's Confidential Enquiry on Maternal Death (CEMDSA) or 'Saving Mothers' reports for 2002 - 2004[10] and 2005 - 2007[11] showed that unsafe abortion contributed to 3.5% and 3.4% of all maternal mortality, respectively. However, in the 2005 - 2007 report, this proportion rose to 4.9% after the figures for misclassified HIV/AIDS-related deaths were adjusted.[11] Unfortunately, in the latest report, for 2008 - 2010,[12] the CEMDSA committee reclassified abortion-related deaths as 'unsafe miscarriage', so the reports are not directly comparable; however, the prevalence was 3.8% for this period*.”[[3]](#footnote-3)

(**No**) allow medical practitioners to refuse provision of a legal medical service on grounds of conscientious objection

* The Choice on Termination of Pregnancy Act sets out guidelines regulating how health professionals can conduct themselves. It does not specifically contain a right to conscientious objection, however it does set out guidelines regarding how health professionals are expected to act.
* According to the Choice on Termination of Pregnancy Act, “*the right to refuse to provide abortion services applies only to the actual abortion procedure. Hence, in terms of the law health care providers who are not directly involved with the abortion procedure cannot use their beliefs as a reason for not assisting a woman seeking abortion services. They also cannot deny routine medical care and general assistance not related to the procedure. A health care provider must also lodge in writing to the employer refusal to participate in performing an abortion. Further, in terms of the constitutional right of all South Africans to emergency health care, a conscientious objector is ethically and legally obliged to care for patients with complications arising from an abortion whether induced or spontaneous*.”[[4]](#footnote-4)

(**No**) prohibit certain medical services, or require that they be authorized by a physician, even where no medical procedure is required; in particular:

(**No**) IUDs (intrauterine devices) or hormonal contraceptives

(**No**) Emergency contraceptives, including the morning-after pill,

(**No**) Sterilization on request (please also include information regarding whether non-therapeutically indicated sterilization is allowed for men);

(**No**) Early abortion (in first trimester of pregnancy) at the pregnant woman’s request

(**No**) Medically assisted reproduction (e.g., in vitro fertilization)

*If yes, please indicate the relevant legal regulations and indicate the sources.*

1. **Are the following acts criminalized?**

*(Please specify in the space provided for this purpose "yes" or "no")*

(**No**) transmission of HIV or other venereal diseases by women only

(**Yes**) female genital mutilation

(**No**) child marriage

(**No**) home births with an obstetrician or midwife

(**No**) abortion

**If yes, are there any exceptions to these prohibitions and under what circumstances do exceptions apply?**

* No exceptions – the South Africa recognizes the right of every female child under the age of 16 not to be subjected to genital mutilation in terms of Section 12(3) of the Children’s Act 38 of 2005.

**And who is criminally responsible?** *(Please circle the appropriate answer)*

* Any persons who contravene this section will be guilty of an offence in Section 305(a) of the Children’s Act 38 of 2005.

1. ***Safety***
2. **Does your country have regulations (in the constitution, legislation or in other legal codes) that guarantee:**

*(Please specify in the space provided for this purpose "yes" or "no")*

(**Yes**) Special protection against gender based violence

* The Criminal Procedure Second Amendment Act 75 of 1995 deals with, among other things, bail guidelines that cover violence against women.
* The Domestic Violence Act 116 of 1998 defines violence against women as including in addition to physical violence, other forms such as emotional, economic, threatened violence and stalking. The legislation imposes protection orders against perpetrators and the possibility of imprisonment of recidivist offenders.
* The Promotion of Equality and Prevention of Unfair Discrimination Act 4 of 2000 defines discrimination on the basis of gender to include gender-based violence.
* The Criminal Law Amendment (Sexual Offences and Related Matters) Act 32 of 2007 criminalizes a wide range of acts of sexual abuse and exploitation. It repeals the common law offence of rape and replaces it with a new expanded statutory offence of rape, applicable to all forms of sexual penetration without consent, irrespective of gender. It also repeals the common law offence of indecent assault and replaces it with a new offence of sexual assault, which contains a wider range of acts of sexual violation without consent. The Act also targets for punishment of sexual predators that prey on children and people with disabilities. It criminalizes sexual exploitation or grooming of children and people with disabilities, exposure or display of child pornography or pornography to children and the creation of child pornography.
* The Protection from Harassment Act 17 of 201 protects victims of harassment (including sexual harassment).
* The Prevention and Combating of Trafficking in Persons Act, Act 7 of 2013 addresses human trafficking by providing a maximum penalty of R100-million or life imprisonment or both in the case of a conviction.

(**Yes**) Equal access for women to criminal justice

* Section 34 of the South African Constitution states: “Everyone has the right to have any dispute that can be resolved by the application of law decided in a fair public hearing before a court or, where appropriate, another independent and impartial tribunal or forum.”
* Section 35(2) of the Constitution states that: Everyone who is detained, including every sentenced prisoner, has the right […] b. to choose, and to consult with, a legal practitioner, and to be informed of this right promptly; c. to have a legal practitioner assigned to the detained person by the state and at state expense, if substantial injustice would otherwise result, and to be informed of this right promptly […]

1. **Are the following acts criminalized?**

*(Please specify in the space provided for this purpose "yes" or "no")*

(**No**) adultery

(**Yes**) prostitution

(If yes, who is criminally responsible – please circle the appropriate answer: the **sex worker**, **the procurer and/or the customer as well as anyone who lives off of the proceeds of sex work**)

(**No**) sexual orientation and gender identity (homosexuality, lesbianism, transgender, etc.)

(**No**) violations of modesty or indecent assault (e.g. not following dress code)

*Please give legal references and provisions.*

* Section 20(1)(A) of the 1957 Sexual Offences Act states that any person who has unlawful carnal intercourse or commits an act of indecency with any other person for reward, is guilty of an offence.
* The Criminal Procedure Act of 1977 also contains provisions relating to prostitution, as do municipal by-laws. The Sexual Offences Amendment Act 2007, section 11, also criminalizes clients.

1. **Are there any provision in criminal law that treat women and men unequally with regard to:**

*(Please specify in the space provided for this purpose "yes" or "no")*

(**No**) Procedure for collecting evidence

(**No**) Sentencing for the same offence, especially capital punishment, stoning, lashing, imprisonment, etc.

(**No**) So called “honor crimes” (are they tolerated in order for the perpetrator to avoid prosecution or to be less severely punished if the woman is killed?)

1. **Diagnosing and counteracting possible sex discrimination in practice in the area of health and safety**
2. ***Health***
3. **Are there legal obligations to provide health education in school?**

Yes **( X** ) No ( )

If yes, does it cover: *(Please specify in the space provided for this purpose "yes" or "no")*

(**Yes**) prevention of sexually transmitted diseases

(**Yes**) prevention of unwanted pregnancies

(**No**) promotion of a healthy lifestyle, including prevention of dietary disorders of teenage girls, including anorexia and bulimia

(**No**) psychological/psychiatric training on self-control of aggression, including sexual aggression

*Please indicate any relevant legal regulation or programs regarding to the above mentions.*

* The National Policy on HIV and AIDS for Learners and educators in Public Schools and Students and Educators in Further Education and Training Institutions (10 August 1999, Volume 410 No. 20372) was implemented in 1999 to respond to the HIV and AIDS epidemic across South Africa. The goals of the national policy are to: provide information about HIV and AIDS to reduce transmission; develop life skills that would facilitate healthy behaviour in youth such as communication and decision-making skills; and develop an environment of awareness and tolerance among youth towards those with HIV and AIDS.

1. **Are there any statistical data disaggregated by age and/or sex regarding :**

*(Please specify in the space provided for this purpose "yes" or "no")*

(**Yes**) malnutrition

* Available data reveals significant levels of under-nutrition among children under the age of 5, although more recent data is not readily available. In 1999, 11.1% of children between the ages of 12 and 71 months were underweight, 23.8% suffered stunting and 3.8% suffered from wasting. Health Systems Trust, South African Health Reviews in Harrison D, 2009, 13. Malnutrition is more common in female-headed households than in male-headed households. In 2008 hunger was present in 2.9 million female headed households compared to 2.1 million male-headed households. General Household Survey, 2008, Statistics South Africa.
* Although encouraging breastfeeding and complementary feeding, Vitamin A and zinc supplementation and the appropriate management of childhood malnutrition has the potential to reduce child mortality by 25%, and stunting by 33% when implemented to scale.[[5]](#footnote-5) This potential has remained largely unfulfilled. The 2005 National Food Consumption survey revealed that there has been an increase in Vitamin A deficiency in children aged 1-5, with a coverage rate of only 20.5%.[[6]](#footnote-6) Despite the fact that almost half of all public hospitals are “Baby Friendly”, coverage for exclusive breastfeeding is a low 7%.[[7]](#footnote-7)

(**Yes**) maternal mortality

* In 2014 Amnesty International reported that “South Africa has unacceptably high rates of maternal mortality. Although the country is seeing improvements since 2011, the number of women and girls who are dying during pregnancy or shortly after giving birth has increased dramatically since 2000. Today, the maternal mortality rate stands at 269 deaths per 100,000 live births, far higher than the rate of 38 which the government committed to achieve by 2015. Experts suggest 60% of maternal deaths in South Africa are avoidable.”[[8]](#footnote-8) In the Millennium Development Goals Report of South Africa, 2013, Statistics South Africa reported that:
  + The 1998 Department of Health Services reported that the maternal mortality ratio was 150 per 100 000 live births during the period 1992–1998.
  + Since 1998, there have been no comparable estimates of MMR in the country. The 2003 DHS did not provide estimates of MMR and no other similar data source is currently available.
  + Maternal Mortality ratio increased from 133 maternal deaths per 100 000 live births in 2002 to 299 in 2007. It increased further to 300 and 312 in 2008 and 2009 respectively, and then dropped to 269 maternal deaths per 100 000 live births in 2010.
* Based on these results, it is concluded that South Africa in still lagging behind the MDG target of 38 maternal deaths per 100 000 live births.
* Additionally, a 2008 report found that every year in South Africa, at least 1,600 mothers die due to complications of pregnancy and childbirth. 27, 000 babies were stillborn, and another 22,000 die before they reach the age of one month; 75,000 children die before their fifth birthday.[[9]](#footnote-9) There are other contributing factors as reported by Amnesty International reported that KwaZulu-Natal, a densely populated province with high birth rates, is home to nearly a quarter of children in South Africa under the age of one. The province had the highest number of maternal deaths in 2011, 23 and the highest provincial-level antenatal HIV prevalence (37.4%). A government-commissioned review of maternal deaths in 2008-10 identified delays in accessing health facilities as a concern in the province. Furthermore, the high number of births taking place outside of health facilities (25.9% in 2010/11) indicated that access to health care services was still a problem for women and girls in KwaZulu-Natal.[[10]](#footnote-10)
* The child mortality rate is four times greater among African children than white children. Diseases stemming from extreme poverty, including low birth weight, diarrhoea, lower respiratory infections and protein-energy malnutrition make up 30% of these deaths.[[11]](#footnote-11)

(**Yes**) maternal morbidity, including obstetric fistula

* The distribution and pattern of maternal morbidity and mortality is determined by demographic inequalities. Maternal morbidity rates coincide with the rates and demography of poverty in South Africa; they are higher in non-urban areas. Births attended by skilled personnel were 91% for the country as a whole. The births attended by skilled health personnel were 85% in rural areas and 94% in urban areas (WHO, 2011).

(**Yes**) adolescent childbearing

* In the 2013 Millennium Development Goals Report, Statistics South Africa reported that “*adolescent child bearing is common in South Africa. The percentage of girls aged 15–18 who had ever had a live birth provides an indication of the prevalence of adolescent childbirth in the general population. Early childbearing age can have a negative impact on the health of the mother and child*.” Further that between 1996 and 2011, at least one in nine girls aged 15–18 in South Africa have had at least one live birth. The census data indicates that the percentage of girls aged 15–18 who had ever had a live birth increased from about 13% in 1996 to about 14% in 2011.
* In 2008, it was reported that 66,000 girls dropped out of school due to pregnancy. General Household Survey, 2008, Statistics South Africa. The rate of adolescent pregnancy is correlated with income inequalities; there are higher rates of pregnancy in poorly resourced schools and in poor neighbourhoods, as well as higher rates in more rural provinces such as the Eastern Cape, Kwa-Zulu Natal and Limpopo.[[12]](#footnote-12)

(**Yes**) health consequences of physical, psychological, sexual and economical gender-based violence

* Psychosocial support services for victims, including shelters and counselling services, are inadequate due to inappropriate budgetary allocations by the State. As a result, the provision of these services has largely been left to civil society. Limited data is available to monitor those services that are provided and linked to gender based violence such as post exposure prophylaxis. Other services such counselling; shelter etc. there is no reliable data as there are no specific services.
* Although the South African government has developed national guidelines for PEP treatment for individuals 14 years and older, there are no corresponding guidelines for children under 14. Many health care providers consequently lack basic information about how, and even in what circumstances, to provide PEP to children under fourteen.[[13]](#footnote-13) Forty percent of child rape survivors did not receive post-exposure phrophylaxis because they refused testing or presented more than the prescribed 72 hours after the rape. Where post-exposure prophylaxis was administered, there were often low follow-up testing rates and low drug adherence rates.[[14]](#footnote-14)

(**Yes**) incidence of HIV/AIDS and sexually transmitted deceases

* South African women between the ages of 15 and 49 are especially vulnerable to contracting the HIV infection – women constitute over half of adults aged 15 and over estimated to be living with HIV and AIDS in South Africa according to the UNAIDS, 2008 Report on the Global AIDS Epidemic, 2008. Young women between the ages of 15 and 24 (12.7%) are significantly more likely than men of the same age (4.0%) to be infected. Around one third of women between the ages of 25 and 29 are HIV-positive and a total of 3,200,000 women older than 15 are HIV-positive.[[15]](#footnote-15) The biggest cause of premature deaths amongst children and women is HIV and AIDS, accounting for 75% of premature deaths, together with tuberculosis.[[16]](#footnote-16)

(**Yes**) drug abuse

* Substance addiction occurs faster in in women than in men. Women addicted to drugs were 46% more likely to be victims of rape, physical abuse and incest.[[17]](#footnote-17)
* Exposure to drugs and alcohol at a young age has a highly detrimental impact on children’s development. In most communities, alcohol can be purchased close to schools – contrary to the legislation that regulates the sale of alcohol. Furthermore, violence and unlawful behaviours are often normalised for children due to this early exposure. This is particularly worrying because in about 50 percent of rapes perpetrated against children, the victim had consumed alcohol or drugs prior to the event. Drugs and alcohol also have an impact on the rate of teenage pregnancy.

(**Yes**) alcohol addiction

* World Health Organization statistics show South Africa is among countries where people show the most risky patterns of drinking in the world. A 2011 report analyzed drinking patterns worldwide and revealed that 41.2% of South African women who did not abstain from were binge drinkers. It said South African women drank an average of 60ml of alcohol a week. South African women were the heaviest drinking women on the African continent, together with Zambian women.

(**Yes**) legal abortions

* 529 410 women have had safe and legal abortions since the introduction of the Choice on Termination of Pregnancy Act in 1997, with 256 808 of these abortions happening in the past three years. In Limpopo, the increase in termination of pregnancy services during the previous nine years has spiked from 533 abortions in 1997 to 4 864 in 2003. Demand for abortion services has exceeded supply, with operational designated facilities decreasing from 60-43%.[[18]](#footnote-18)

(**Yes**) death resulting from legal abortions

* A comparison between the 1994 study and the 2002 - 2004 Confidential Enquiry into Maternal Death, which found a 91% reduction in deaths from unsafe abortion.[[19]](#footnote-19)

(**No**) illegal abortions

(**Yes**) death resulting from illegal abortions

* The National Committee on Confidential Enquiries into Maternal Deaths provides that 4 867 maternal deaths were recorded between 2008 and 2010. 186 of those women died of a septic miscarriage in public healthcare facilities, 23 percent of which were the direct result of an unsafe abortion.[[20]](#footnote-20)

(**Yes**) use of contraceptives, including mechanical and hormonal (including emergency contraceptives)

* The United Nations Population Fund found that around 60% of South African girls and women aged 15-49 use modern contraceptives; higher than the sub-Saharan average of 20% and closer to the global average of 57%.

(**YES**) sterilization on request

* The most recent data on sterilization is from 1998. It shows that the prevalence of sterilization (both female and male) in South Africa for couples is at 18% - lower than Asia, Latin America and the Caribbean, and North America, but higher than much of Africa. In 1998 approximately 860, 000 people used sterilization.[[21]](#footnote-21)

1. **Are there any statistical data and/or estimations regarding the number of reported and/or unreported cases and convictions for :**

*(Please specify in the space provided for this purpose "yes" or "no")*

(**No**) female genital mutilation

(**No**) illegal voluntary abortion

(**No**) forced abortions

(**No**) forced sterilizations

(**No**) malpractices in cosmetic medicine

(**No**) obstetric violence

*If “yes”, please give further references.*

1. **Is the gender perspective included in national health-related policies:**

**Yes** ( X ) No ( )

**In particular:** *(Please specify in the space provided for this purpose "yes" or "no")*

(**Yes**) in planning the distribution of resources for health care

(**No**) in medical research on general diseases, with proper and necessary adaptations to the different biological make-up of women and men

(**No**) in geriatric service provision

(**No**) in state custodial decisions to institutionalize children between 0-3 years old

**Explanation**: *The need for a gender-based approach to public health is connected with the necessity to identify ways in which health risks, experiences, and outcomes are different for women and men and to act accordingly in all health related policies. There are existing advocacy campaigns on the need for the development and implementation of a Women’s Health Policy.*

1. ***Safety***
2. **Are there any national policies regarding women’s safety in public spaces?**

Yes ( ) **No** ( X )

*If “yes”, please give references.*

1. **Have there been any public opinion research polls on the fear of crime among women and men (over the last 5 years)?**

**Yes** ( X ) No ( )

*If “yes”, please give references and the outcomes of such research polls.*

* Gallup data from surveys in 143 countries in 2011 suggest men and women often did not share the same sense of security in public places. 33% of South African Women said they felt safe walking around at night, compared to 44% of men. [[22]](#footnote-22)

1. **Are there any measures and programs undertaken in order to increase women’s safety e.g. in public urban spaces, in public transportation, etc.?**

**Yes** ( X ) No ( )

*If “yes”, please give references.*

* The Johannesburg Human Development Strategy contextualized the Women’s Health Implementation Plan (June 2005 to November 2010) and the Women’s Safety Implementation Plan (June 2005 to November 2010). These Plans contained a number of projects that had been identified for promoting women’s health and safety issues over the following five years in the city of Johannesburg.

1. **Are there any statistics on crimes amounting to violence against women in public spaces and/or domestic violence?**

**Yes**  ( X ) No ( )

* Women in South Africa experience among the highest levels of gender-based violence[[23]](#footnote-23) in the world. Sexual violence statistics do not provide a true reflection of the problem given that these crimes are greatly underreported, often due to stigmatization and a lack of survivor-friendly services. This is confirmed by the South African Law Commission (“SALC”), which estimates that about 1.69 million rapes occur every year, but on average only 54,000 rape survivors lay charges each year.[[24]](#footnote-24) A recent SAPS study estimates that authorities are only informed of 1 in 36 incidents of rape, which translates to about 2.8 percent of all cases.[[25]](#footnote-25)
* Domestic violence has been described as one of the most prominent features in post-apartheid South African violence.[[26]](#footnote-26) The South African Police Services (“SAPS”), in their report for January 2010 to December 2010, recorded 100,877 cases of domestic violence. [[27]](#footnote-27) The issue of underreporting seems to lie, at least in part, with two factors. Firstly, the belief that domestic violence is a private affair that is not subject to public scrutiny or regulation. Secondly, the stigma attached to domestic violence where survivors feel embarrassed and vulnerable.
* The World Health Organization found that 60,000 women and children are victims of domestic violence in South Africa every month. World Health Organisation, Intimate Partner Violence, WHO/RHR/12.36, 2012.
* Access to the police and court-based protection in regards to domestic abuse is severely stratified by geographical location, literacy and poverty levels. Studies indicate that only 6% of rural women, compared to the 41% of women in urban areas who are abused, make use of the legal protection provided by the law. Vetten L., 2007, Violence against women in South Africa: State of the Nation 2007, HSRC.

1. **Is the sex of the victim reflected in the police, prosecutors and courts records?**

**Yes** ( Yes ) No ( )

*If “yes”, please give references.*

1. ***Health and Safety***
2. **Are there any data and/or results of research on the detrimental influence of the feeling of insecurity and unsafety on women’s mental health?**

**Yes** ( X ) No ( )

* Women have been found to experience increased mental health issues linked with sexual violence, re-infection, and issues related to fertility, partum depression and depression related to HIV- AIDS. Moreover, repeated trauma and experiences of violence predispose HIV-positive women to depression. [[28]](#footnote-28)

1. **Are there specific health and safety protective measures for women , and/or with special provisions for mothers with young children, in “closed” institutions including in:**

*(Please specify in the space provided for this purpose "yes" or "no")*

(**Yes**) prisons (e.g. measures similar to the Bangkok Rules),

* The Correctional Services Act (1998) mandates that Department of Correctional Services ‘must provide, within its available resources, adequate health care services, based on principles of primary health care, in order to allow every inmate to lead a healthy life.’ Correctional Services Act Chapter 3. However, there is no specific reference to gender.
* The South African prison system allows women with children of up to two years of age, and in some cases up to four years, to keep the children with them in prison. Chapter V of the Correctional Services Act also includes the provisions for services to be provided to pregnant women.

(**Yes**) police detention cells

* Visits to female persons in custody, where a female member is not available, have to be made by a female warder, special matron or other suitable woman, accompanied by a male member.[[29]](#footnote-29)

(**No**) psychiatric hospitals,

(**No**) pre-deportation centers,

(**No**) camps for displaced women and families (if relevant),

* 2000 women, men and children from Malawi, Zimbabwe, Mozambique and Burundi have been displaced to refugee camps in townships across KwaZulu-Natal following outbreaks of xenophobic violence. Vumani Mkhize, Humanitarian Crisis Grows in Xenophobic Hit KZN, Eyewitness News, May 2015.

(**No**) nunneries

(**No**) women’s shelters

*If “yes”, please provide any information about the protective measures established.*

1. **Are there specific training programs for medical and legal professionals on the issue of gender-based discrimination in the area of health and safety?**

Yes ( ) **No** ( X )

Do they cover: *(Please specify in the space provided for this purpose "yes" or "no")*

(**No**) the issues connected with specific women’s needs in area of health

(**No**) specific women’s vulnerability to be victims of gender-based violence or specific crimes, covering e.g. the issues of:

(**No**) the nature of gender-based violence,

(**No**) its occurrences and symptoms

(**No**) methods of detection

(**No**) medical protocols

(**No**) influence of gender based violence, in particular of sexual violence on the future behaviors of victims (post-traumatic stress symptoms etc.)

1. **Could you please indicate any legislative reform, policy or practice, that you consider “good practice” regarding health and safety for women in your country?**

**If yes, please indicate on which criteria your definition of “good practices” is based.**

* A perinatal mental health programme (PMHP) was initiated in 2002 at Liesbeeck Midwife Obstetric Unit (MOU) at Mowbray Maternity Hospital, Cape Town. The goal of the program was to provide holistic mental health services when women are receiving obstetric care, and help alleviate maternal mental distress. The program helps focus the health system on emotional as well as physical issues, and has been successful in addressing the mental health needs of mothers as well the physical.

**Prepared by:**

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**on behalf of the**

**Legal Resources Centre**

*ENDS*

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