What was done in South Africa and what can be learnt from it

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Background to the Women and Gender Equity Knowledge Network

The Women and Gender Equity Knowledge Network (WGEKN) of the WHO Commission on Social Determinants of Health was set up to draw together the evidence base on health disparities and inequity due to gender, on the specific problems women face in meeting the highest attainable standards of health, and on the policies and actions that can address them.

The work of the WGEKN was led by two organizational hubs – the Indian Institute of Management Bangalore (IIMB) and the Karolinska Institute (KI) in Sweden. The 18 Members and 29 Corresponding Members of the WGEKN represent policy, civil society and academic expertise from a variety of disciplines, such as medicine, biology, sociology, epidemiology, anthropology, economics and political science, which enabled the work to draw on knowledge bases from a variety of research traditions and to identify intersectoral action for health based on experiences from different fields.

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Case study

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CURRENT STATISTICS (Sources: Ijumba and Padarath 2006; Barron et al. 2006; UNDP 2007; Benjamin 2007)

**Population:** 47.4 million  
**Water access:** 85% of households have access to piped water. There is great variation in access to water across districts with 90% of metro (Cities) having access to piped water yet some rural areas particularly in the Eastern Cape only having 28% access to piped water.  
**Gini Coefficient:** 0.722  
**Human Development Index:** 0.653  
**Gender-related Development Index:** 0.646  
**Unemployment:** 26%  
**Life expectancy:** 47 years  
**Energy supply:** 40% experienced at least periodic shortages of fuel for cooking or home heating. 61.3% used electricity for cooking  
**Mortality:** HIV (51%) is the leading cause of death of women aged 15-54 years  
**Connectivity:** 28 million out of 47 million people have cell phones. 98% of public health clinics have a cell phone

**Women’s Health and Sexual and Reproductive Health and Rights** (Sources: Ijumba and Padarath 2006; Barron et al. 2006; Gabriel 2006)

**Rapes reported:** 55 1114 reported from April 2004 –March 2005.  
**Incidence:** 143 per 100 000  
**PPTCT:** 51% of HIV positive pregnant women accessed neviripine  
**Total Fertility rate:** 2.7  
**Contraception rate:** Use of ‘family planning’: 65%  
**Antenatal care attendance:** 95%  
**Abortion:** There have been 529 410 safe and legal pregnancy terminations during the ten year period (1997 to 2006) since the introduction of the Choice on Termination of Pregnancy (CTOP) Act in February, 1997. This has led to a 90% reduction in maternal mortality and morbidity in relation to abortion.  
**Abortion Facilities:** 51% of designated facilities functioning  
**Maternal death:** 150/100 000. The main reasons for primary obstetric death are non-direct causes of non-pregnancy related infections. Maternal deaths (deaths during pregnancy and the puerperium) was made notifiable condition in 1997. The National Committee for Confidential Enquiries into Maternal Death (NCCEMD) secretariat is responsible for coordinating the process or notification and reporting and making recommendations
Caesarean Rate: 18.4%

HIV/AIDS and other STIs (Sources: Ijumba and Padarath 2006; Barron et al. 2006; Xundu 2007; Moodley 2006)

Estimated number of people living with HIV: 5.5 million
Antenatal HIV prevalence 29%
Overall adult prevalence rate: 18.8%
Average STI incidence: 4.8% (This indicator measures the percentage of people 15 years and older who have been treated for a new episode of a sexually transmitted STI)
Incidence in terms of gender and age: Women are disproportionately affected: accounting for approximately 55% of HIV positive people. Women in the age group 25-29 are the worst affected with prevalence rates of up to 39.5%
HAART treatment: January 2007 250 000 on treatment in government public sector and 100 000 on treatment in private sector
AIDS Defining Illnesses: The incidence of cervical cancer is 30:100 000. There is presently an increase in pre-cancerous lesions in HIV positive women. Cervical Cancer is the leading cause of cancer mortality in South African women.

Children (Source: Barron et al. 2006)

Immunisation coverage measures the percentage of children under one year who have completed their primary course of immunisation. The national target of 90% was achieved during the year and this is one of the success stories of PHC in South Africa. Linked to this was the great achievement of South Africa being declared a polio free country in 2006.
Diarrhoea: 258 new cases of diarrhoeal disease per 1000 under five in 2005
Perinatal mortality 34 per 1000 births in 2005

THE CONTEXT OF WOMEN’S HEALTH IN SOUTH AFRICA
Following the change of government in 1994 rapid strides were taken to prioritize women’s health. In the first 100 days of President Mandela’s presidency, an announcement was made that primary health care was to be free to pregnant women and children under six. This was to ensure that poor women and their children had access to care. These broad strides were welcomed and heralded a period of significant policy and legal change orientated to the poorest of the poor. This took place when the health care system itself was transforming towards developing an integrated and decentralized health care system based on primary health care. Subsequently primary health care was made freely available to all citizens in the public sector. Health workers were not prepared for
this and in retrospect have become overwhelmed with what is commonly termed ‘change fatigue’. Efforts continued to increase access to health broadly and are clearly defined in the South African Constitution in section 27 in the clause ‘Health care, food, water and social security’. It states: ‘(1) Everyone has the right to have access to (a) health care services, including reproductive health care; (b) sufficient food and water; and (c) social security, including, if they are unable to support themselves and their dependents appropriate social assistance. (2) The state must take reasonable legislative and other measures within its available resources, to achieve progressive realization of these rights, (3) No one may be refused emergency care treatment’ (Klugman 1998). While efforts have been made to implement this with over 4000 public health facilities employing some 235 000 personal, care is sometimes sub-optimal, public facilities have long waiting times and primary care facilities have too few doctors (Barron et al. 2006). In relation to broader determinants of public health many people do not access to clean water, sanitation, nutrition, electricity and safety which facilitates poor health. Poor people face the high costs of transport, buying medicines, and follow up visits to a doctor. Language barriers between patients and health workers mean that many people many not be able too fully understand their treatment. Many women experience domestic violence, sexual offences and other forms of violence against women. There are discriminatory attitudes amongst health care workers against people because of their race and gender. Because of the HIV/AIDS crisis, many hospitals and clinics face a huge increase in patients, but there has not been an increase in the doctors and nurses available to care for all the new patients. The health care system is better equipped and provides better services in provinces like Gauteng and the Western Cape, than in others such as the Eastern Cape and Limpopo.

It is perhaps important to underline the period of ‘transformational flow’ or ‘soft boundaries’ during the period of about 1994-1998. This period was characterized by a flow and political ease in which policy change at addressing the apartheid past was welcomed. It was enabled by relationships which spun a network into various institutions including parliament, political parties, the media, government departments and NGOs. There was an element of trust and the need to work collaboratively to address the past
imbalances that characterized South Africa. As Black women were known to have borne
the brunt of apartheid’s evils, women’s rights were acknowledged as human rights and
there was an understanding that laws and policies needed to put in place to correct this.

**LAWS AND POLICIES ADDRESSING WOMEN’S HEALTH**

While there were broad reforms addressing issues of equity and women’s health, there
have also been very specific changes. These include: The Choice on Termination of
2004, the Notification of and Confidential Enquiry into Maternal Deaths (NCCEMD),
The Sterilization Act, 2000, Contraception policy guidelines and the Comprehensive plan
for the management of HIV and AIDS and the HIV and AIDS National Strategic Plan
2007-2011. In highlighting a few of these areas:

1. While South Africa has liberal abortion law which has successfully reduced abortion
related maternal mortality and morbidity, demand for services exceeds supply and health
workers have not easily accepted the provision of this service. The law is constantly
under attack from anti-choice activists. The media is not helpful and in 2006, services
were suspended for two weeks in the Northern Cape as service providers thought the
legislation had been repealed

2. The NCCEMD is a process designed to evaluated, indirectly, the quality of care that
women receive during pregnancy and childbirth. It is evident that AIDS is proving to be
the largest challenge to addressing maternal mortality in South Africa.

3. As part of the a HIV/AIDS continuum of care, the programme for the prevention of
mother to child transmission PMTCT was the first step in improving the health care of
pregnancy women infected with HIV in that it helped to identify those pregnant women
who were HIV positive. The South African PMTCT programme was largely introduced
as a vertical programme to allow for central control and faster implementation; however
the result is that it does not function integrally with broader maternal and child health
services. The indicators suggest that many opportunities to prevent mother to child
transmission are being missed. The orientation of the programme has also been to
emphasis the child’s health and not the mothers’ health which has been problematic.
The period of policy has changed and is not as open and easy as in the late nineties. The Sexual Offenses Bill was passed in Parliament in May 2007 and has been in the making for some ten years. While it has been welcomed as a positive change by activists, it still falls short in including clear regulations concerning integration of health, justice and safety and security which would make the law implementable.

HEALTH SYSTEMS CHALLENGES
As noted all of these developments have taken place in a transforming health system. There has been increased expenditure in primary health for capita from – R168 in 2001 to R232 in 2005. The average clinical workload of a nurse was 31.6 patients a day in 2005. And the primary health care utilization rate is the average number of visits a person per year to a public PHC facility which in 2005 was 2.1 (Barron et al. 2006). The challenges of South Africa are complex as it is a profoundly inequitable country as noted by the gini coefficient. There are consistent efforts to spread the resources and transform the health system. In developing systems to increase the supply of health workers in rural areas health graduates have a compulsory community service year and there is a rural allowance for certain health workers.

THE ROLE OF LEADERSHIP AND CIVIL SOCIETY
As noted in this case study, HIV/AIDS is the challenge that is affecting women health in their reproductive years. There have been enormous difficulties and complexities in delivering leadership around HIV/AIDS in South Africa led to a number of missed opportunities, confusion and what is know as ‘denialism’. In the recent past there has been excellent leadership demonstrated by the Deputy President of South Africa (Mrs Phumzile Mlambo Ngcuka) and Deputy Minister of Health (Mrs Noziwe Madlala-Routledge) who have engaged and lead the processes of the South African National AIDS Council and the new National Strategic Plan for HIV/AIDS (Department of Health 2007). Prior to this there has been a re-emergence of strong social movements as in the Treatment Action Campaign (TAC), The Social Movements Indaba and the Anti-Privatization Forum (fighting the privatization of basic services of water and electricity).
TAC has been successful in litigating for the access to HAART and for increasing treatment literacy amongst activists.

It is important to note that the recent past has been characterized by a lack of leadership and mistrust of politicians. As the country matures in finding its identity, so have activists who previously would have made things happen in across various institutions. There is a period of ‘hard boundaries’ where there appears to be tiredness and a sense of poor morale.

While the HIV/AIDS sector has embraced the concern of general equity issues, women’s sexual and reproductive health and rights in relation to HIV/AIDS are not being explored and addressed with the same vigour and passion.

References


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