JOINT SUBMISSION

TO THE

UNITED NATIONS SPECIAL RAPPORTEUR ON THE RIGHT OF EVERYONE TO THE ENJOYMENT OF THE HIGHEST ATTAINABLE STANDARD OF PHYSICAL AND MENTAL HEALTH

on the

Thematic Report: Violence and its impact on the right to health

Submitted by the following organisations with input and contributions from:

Women's Legal Centre

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I. INTRODUCTION

We refer to the call for written submissions by the United Nations Special Rapporteur on The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health for input to a thematic report: **Violence and its impact on the right to health.**

We hereby respond to this call and accordingly provide this submission for consideration in the development of this thematic report. We welcome and appreciate this opportunity to make written submissions.

II. INTRODUCTION TO THE AUTHORS OF THE SUBMISSION

The **Women's Legal Centre** ("The WLC") is an African feminist legal centre that advances women's rights and equality through strategic litigation, advocacy, education, and training. We aim to develop feminist jurisprudence that recognises and advances women's rights. The Centre drives a feminist agenda that appreciates the impact that discrimination has on women within their different classes, race, ethnicity, sexual orientation, gender identity and disability. The Centre does its work across five programmatic areas including the right to be free from violence, women's rights in relationships, and women's rights to land, housing property and tenure security, women's sexual and reproductive health rights and women's rights to work and at conditions of work.

Website: www.wlce.co.za

Her Rights Initiative (HRI) is a social impact organisation formed in 2009 to advocate for the sexual and reproductive rights of women, particularly women living with HIV in South Africa. HRI is made up of a group of feminists and women rights advocates claiming their human, sexual and reproductive rights in the context of HIV. Their vision is to create a world where all women including women living with HIV enjoy all their Constitutional rights which are realised and affirmed.

The Sexual Rights Initiative is a coalition of national and regional organizations based in Argentina, Canada, Egypt, India, Poland, and South Africa that work together to advance human rights related to sexuality at the United Nations.

Website: https://sexualrightsinitiative.com/

III. THE INFORMING CONTEXT OF THE SUBMISSION

a. Discrimination based on gender and/or gender identity experienced by women is complex and diverse as it is inextricably linked to other identities and contexts that women navigate, and which affect their lives. As shown in many contexts oppression, discrimination and exclusion are interlinked. This is commonly referred to as intersectionality. Reference to women in this case must therefore ensure that certain stigmas and prejudices of womanhood are dismantled and responded to. To this end, reference to women/gender includes women in all their diversity.

b. In South Africa, Apartheid's legacy of inequality and violence has placed poor Black women in a particularly vulnerable position. The government of South Africa has recognised the persisting triple

challenge faced by South Africa of unemployment, poverty and inequality and that women, black people and young people are disproportionately impacted by the intersection of these challenges.

c. In its 2019 research brief titled 'What Drives Violence in South Africa', the Centre for the Study of Violence and Reconciliation (CSVR) found that "[in] South Africa's patriarchal society, where men are generally expected to be unconditionally powerful providers, not having the resources to play this role creates the conditions for violence. Poverty increases the likelihood of being both a perpetrator and a victim of gender-based violence, and especially intimate partner violence".
d. This gendered aspect to contact crimes was also recently recognised by the Constitutional Court in *Tshabalala v The State; Ntuli v The State* where it was found that:

   "*Violent crimes like rape and abuse of women in our society have not abated. Courts across the country are dealing with instances of rape and abuse of women and children on a daily basis. The media is in general replete with gruesome stories of rape and child abuse on a daily basis. Hardly a day passes without any incident of gender-based violence being reported. This scourge has reached alarming proportions*."
e. The concurring judgment of Khamepe J in the same case also expressly recognised the intersection of crime, race, and poverty by acknowledging that:

   "*Rape is a scourge that affects women of all races, classes and sexual orientations, but we know that in South Africa rape has a pernicious effect on black women specifically. To erase the racial element in this epidemic is to erase the experiences of the women of that horrendous night. This "intersectional erasure" is a rhetorical gesture that not only negates the lived experience of women at these intersections of oppressed identities but also means that our response to the crisis will always be deficient and under-inclusive. Speaking of rape on these terms is not a preoccupation with personal identity but an analysis of the ways in which power impacts particular women*."
f. As this report includes some specific experiences of women living with HIV, we wish to note that:
   i. The persistence of the HIV epidemic in South Africa and the related intersectional burdens faced by women based on race, gender, age, class social origin and pregnancy has devastating impacts on the health outcomes and realisation of the rights of black women living with HIV in South Africa.
   ii. The HIV epidemic disproportionally affects young Black women. More women than men specifically young women are eight times more likely to be HIV positive. There are various factors that increase the risk of young women contracting HIV which are include women's traditional subordinate role in society; the expectation of women to fulfil caretaking responsibilities; violence; "*the general misinformation regarding and ignorance regarding HIV; disrupted family and communal life due in part to apartheid, migrant labour patterns and high levels of poverty; and finally, the existence of a settled transport infrastructure allowing for the high mobility of persons and therefore the rapid movement of the virus into new communities*."
   iii. Customary practices and habits that entrench women as subordinates in their homes and society and exploit them for the benefit of men especially in intimate partner settings, increase women's vulnerability to contracting HIV. For instance, resistance to use condoms because of distinct sexual, cultural norms, values and "social norms which allow or promote high numbers of sexual partners especially among men; the phenomenon of an extended family household structure; preference for male children; the practices of polygamy; the bride price; wife inheritance, the prevalence of superstition, and adherence to the culture of silence." Such norms and value systems hinder women's ability to negotiate safer sex.

IV. RESPONSES TO QUESTIONNAIRE PROVIDED

1. **Please describe, share data and information on the characteristics, number of cases, and the profile of victims and perpetrators in your country/ies or region(s) regarding:**

1.1. **Gender-based violence against women:**

1.1.1. Gender-based violence perpetrated by men against women has been purported to be the second pandemic facing South African society. Violence against women is rampant due to several reasons. One author explained, a patriarchal *cultural system of indoctrination in South Africa has also created socialised gendered notions of male power and control, where violence is used to affirm masculinity. In this system, women are taught to be submissive to victimisation and men are taught to be dominant and abusive.*[1] Other reasons include inadequate state and non-state responses to address persisting patriarchal and racist norms, inequality and raging poverty among other social challenges in South African communities.

1.1.2. Most recently an address by the President of South Africa in 2021, documented the staggering reality of the increase in violence and particularly rape of predominantly women between July and September 2021.[2] This reality is substantiated by the statistical overview by Statistics South Africa (STATS SA) revealing that one in five women has experienced physical violence at the hands of their partners.

1.1.3. The statistics on violence in South Africa indicate that the intersection of certain identity traits and positionality like poverty, marital status, race, HIV status and education impacts the pervasiveness of physical and sexual violence women experience.[3]

1.1.4. Other statistics on violence against women have indicated that of the percentage of assaults between 2018/2019, almost 50% of assaults were committed by close friends or acquaintances, 15% being spouse or intimate partner violence and 13% being relatives or other household members, with the remaining 29% of assaults being committed by unknown persons.[4] Furthermore, in 2016/2017, 250 out of every 100 000 women were victims of sexual assault.[5]

1.1.5. Statistics on reported cases of violence against women is an immense challenge in South Africa. Although there are many factors that contribute to inaccurate data, research has consistently echoed the public perception and experience that "the police would do nothing or can do nothing" as one of the primary reasons why crime is not reported to the police and particularly sexual offences and assault of women. It has been noted by STATS SA that statistics become unusable especially in sexual offences cases as the error levels for reporting are too great.[6]

1.1.6. However, although the data is fragmented, crime statistics show that women are particularly vulnerable to sexual offences in South Africa, as the 2016/2017 report on

[1] Toxic Masculinity and violence in South Africa, available at https://www.saferspaces.org.za/understand/entry/toxic-masculinity-and-violence-in-south-africa [Accessed on 18 January 2021]

[2] South African Government's 'From the desk of the President' available at https://www.gov.za/blog/desk-president-95 (accessed 11 January 2022).

[3] Stats, S. A. "Crime against women in South Africa." Stats SA (2018).

[4] Stats, S. A. "Crime against women in South Africa." Stats SA (2018).

[5] Stats, S. A. "Crime against women in South Africa." Stats SA (2018) 8.

[6] Stats, S. A. "Crime against women in South Africa." Stats SA (2018) 19,20.

crime against women records that, 68,5% of women are victims of sexual offences in South Africa[7]. This is largely because sexual offences are a regular feature of South African communities because of unequal power relations between women and men. The links between toxic masculinity and rape caused by the male need for power, control, dominance, and misogyny by punishing women for emasculating them, among other reasons has been argued to be what puts women perpetually at risk of sexual violence.[8]

1.1.7. Research trends indicate that although violence is perpetrated by all genders, in South Africa women and children are disproportionately affected by an intimate partner and sexual violence perpetrated by men.[9]

1.2. **Gender-based violence against LGBTQI+, or other persons based on real or imputed sexual orientation, sex characteristics, and gender identity:**

1.2.1. Violence against LGBTQI+ persons is underpinned by societal stigma, homophobia, transphobia, patriarchal norms and oppression and intersex phobia, and is driven by a misunderstanding of an individual's sexual orientation. Transgender persons are at risk of gender-based violence because their identity represents a direct challenge to traditional gender norms and roles. This challenge to traditional and stereotypical gender norms and roles exposes transgender persons to "stigma, harassment, and sexual and physical violence at the hands of family members, their communities, and state actors (such as the police and judicial system). Not only does this violence deprive them of basic human rights, but it also increases their risk for HIV, mental health problems, and poverty."[10]

1.2.2. Gender identity and body diversity (particularly intersex variations) in South Africa are still misunderstood. As a result of cisnormative and heteronormative conceptions of gender, a lot of transgender women are still perceived as "gay men" and transgender men as "lesbian women". Violence against transgender men is often unreported and unpunished, or conflated and misreported in statistics of rapes misconstrued as "corrective" which are often framed as an issue solely in the lesbian community, particularly in townships.

1.2.3. Further, violence against transgender persons is reinforced by a culture that views masculinity as dominant and femininity as subservient. Such violence is still misunderstood and often characterised as violence motivated by the victim's sexual orientation, rather than by their gender identity and gender expression. South African society still understands gender along cisnormative lines and follows a biological-determinist model of gender identity and gender expression. This makes it extremely hard to obtain statistical data on transgender persons in South Africa.

1.2.4. Intersex persons in South Africa are subjected to widespread intersex phobia, verbal and physical violence, and gross human rights violations in the medical sector. These include but are not limited to non-consensual, medically unnecessary treatments and surgeries and being put on medical display so that their bodies and genitals can be

[7] Stats, S. A. "Crime against women in South Africa." Stats SA (2018) 19.

[8] Toxic Masculinity and violence in South Africa, available at https://www.saferspaces.org.za/understand/entry/toxic-masculinity-and-violence-in-south-africa [Accessed on 18 January 2021]

[9] Saferspaces' "Gender-based violence in South Africa" available at https://www.saferspaces.org.za/understand/entry/gender-based-violence-in-south-africa (accessed 12 January 2022).

[10] Kate Giles, 'Gender-Based Violence Against the Transgender Community Is Underreported' available at http://www.prb.org/Publications/Articles/2011/gender-based-violence-transgender.aspx

treated as curiosities. [11] They face compounded obstacles of invisibility, isolation, misunderstanding, stigma, secrecy, shame and pathologisation. [12]

1.2.5. It has been reported in the South African media that in some areas there may be a practice of murdering intersex infants shortly after birth: "We interviewed 90 midwives … 88 of them said when a child with ambiguous genitalia is born, they will twist the child's neck, killing it, because it is a product of a bewitched or cursed family," Griqua said. The mother would be told that her child was stillborn. […] In 2010, a principal at a school in Ga-Ntatelang village near Kuruman undressed a six-year-old child, who had ambiguous genitalia but preferred to use the girls' toilets and forced the child to use the boys' toilets instead."[13]

1.3. **The intersection of violence against women and HIV status**

1.3.1. The relationship between GBV, interpersonal violence, and HIV is bidirectional and closely connected.[14] *'Violence against positive women is any act, structure or process in which power is exerted in such a way as to cause physical, sexual, psychological, financial or legal harm to women living with HIV.'*.[15]

1.3.2. In HRI'S experience, some women are at risk of interpersonal violence following disclosure of HIV status, which means that there is a direct link to violence against women and disclosure of status. Targeting of women for HIV testing has a direct link to VAW against women living with HIV which subjects such women to blame for HIV infection. This is because the person who tests first is often assumed as the person who brought HIV into the relationship and family. An example of this is the case of Gugu Dlamini that HRI has encountered in their work.

1.3.2.1. Gugu Dlamini was murdered for disclosing her HIV status to her partner and family. Her disclosure was a direct consequence of the National Association of People Living with HIV in collaboration with the Department of Health encouraging HIV positive people to disclose their HIV status. This was known as the Disclosure Campaign.

1.3.2.2. Gugu Dlamini was stoned to death after giving her personal account at a World AIDS Day event (as a NAPWA member) in KwaMashu Poly Clinic.

1.3.2.3. Gugu Dlamini was not the first or the last HIV positive woman to be murdered but unfortunately STATS SA has not documented the murders of HIV positive women who are murdered because of their HIV status.

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[11] Iranti-Org. 2015b. ICD intersex workshop. Video made during a regional African intersex workshop on the International Classification of Diseases (ICD), hosted by Iranti-Org, Gender DynamiX and GATE, 27 September 2015. Accessed 23 October at https://www.youtube.com/watch?v=4med0vTOzU0. See also Soldaat, N. 2006. The story of my life. In T. Shefer, F. Boonzaier & P. Kiguwa (Eds.), The gender of psychology. Cape Town: Juta Academic/UCT Press , 267–269. See also Van Rooyen, J. 2015. Understanding social inclusion or exclusion of intersex people living in South Africa. MSc thesis, Trinity College Dublin.

[12] Mokoena, N. 2015. Remembering Sally, and the intersex movement in South Africa. Intersex Awareness Day. Accessed 28 October 2015 at http://intersexday.org/en/remembering-sally-southafrica/. See also Husakouskaya, N. 2013. Rethinking gender and human rights through transgender and intersex experiences in South Africa. Agenda 27(4): 10–24.

[13] John, Victoria. 2012. Gentle man's brutal murder turns spotlight on intolerance. Mail & Guardian Online, 28 June 2012. http://mg.co.za/article/2012-06-28-gentle-mans-brutal-murder-turns-spotlighton-intolerance

[14] Kasiram M, I. et al. 'HIV/AIDS AND WOMEN: SOUTH AFRICAN PERSPECTIVES' (2013)12:1. *African Journal of Indigenous Knowledge Systems.* Pg. 68. See: https://www.researchgate.net/publication/265595300_HIVAIDS_AND_WOMEN_AFRICAN_AND_SOUTH_AFRICAN_PERSPECTIVES/link/54136a610cf2788c4b3597dd/download

[15] Hale, Vazquez, 2011.

1.3.2.4. We do however read stories in the media and hear HIV infection mentioned as defence by perpetrators in Courts.

We've also noted in our work that the experience of violence is often worsened when women are targeted for testing during a pregnancy. This is in addition to the fact that pregnancy by its very nature - without HIV concerns – increases risk of violence to women of low socio-economic status.

1.3.3. The fear or threat of violence may also act as a barrier to treatment uptake and adherence and may disrupt HIV treatment services and result in poorer HIV outcomes. *"Compared with an HIV-negative woman, a woman who discloses her HIV-positive status to a partner of unknown HIV status is more likely to experience physical and emotional abuse."*

1.3.4. Women (and men) who have been subjected to GBV are more likely to engage in behaviours, such as alcohol or drug abuse, which can increase their risk of acquiring HIV. [16] "In South Africa, women with violent and controlling male partners were 1.5 times more likely to acquire HIV compared with women who had not experienced partner violence." [17] In HRI's experience working with women living with HIV we've also found that an HIV positive diagnosis for a woman does not suddenly mean the end of her violent relationships; in fact, such a diagnosis tends to mean that the violence will take a different nuance.

1.3.5. Structural, cultural, and direct violence against women living with HIV is an integral part of the experience of being an HIV positive woman. This ecological model of responding to VAW identifies society, community, relationship and individual as four forms and sites of VAW.[18]

1.3.6. There is an overlap of social determinants of HIV infection and social determinants of violence. This suggests that often the violence experienced by HIV positive women mirrors violence experienced by women generally. HIV positivity, however, exposes women to violence in new situations.[19] HIV positivity becomes one more determinant of violence against women.

1.3.7. The HIV positivity induced forms of violence often intersect with pre-HIV positivity forms. One example can be found in the violent experiences of HIV positive women who are victims of forced sterilisations as explained below. The work done by HRI has shown that HIV positivity pushes women further down the hierarchy of power in society. This makes it harder for women living with HIV to attract social solidarity or successfully seek justice for violence.

1.3.8. Further, in the experience of the work done by HRI, the current framework of prosecution for sexual offences as provided in Chapter 5 of the Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007 directly exclude some HIV positive women from seeking justice for rape. This law was amended to punish male rapists who have HIV. It is assumed that the rapist had the intention to infect the rape victim if he was aware of HIV status when he committed the rape. Now when HIV positive women report rape and are booked for an HIV test, they disclose the fact that

[16] [SAMJ December 2016, Vol. 106, No. 12, "The dual burden of GBV and HIV in adolescent girls and young women in South Africa']

[17] [SAMJ December 2016, Vol. 106, No. 12, "The dual burden of GBV and HIV in adolescent girls and young women in South Africa'] Lancet 2010; 376 (9734): 41 –48. See footnote 11]

[18] Heise, 1998; Dahlberg & Krug, 2002; World Health Organization & London School of Hygiene and Tropical Medicine, 2010).

[19] Hale and Vazquez, 2011.

they already have HIV infection. The immediate response from the police and post-exposure care worker is 'did you disclose your HIV status?'. This turns the rapist into a victim as providers then blame HIV positive women for not disclosing their status to their rapist. This then somehow gets to the defence lawyers and other service providers of the accused and becomes the subject of discussion in Court (if she decides to continue with the case); Thereby humiliating the women living with HIV. In our view, this makes HIV prevention programmes and responses violent towards women living with HIV and highlights why a critical feminist analysis of these programmes and laws is urgent.

1.4. **Please share analysis and available evidence on the impact of COVID on the above**

1.4.1. The South African government on several occasions acknowledged high rates of gender-based violence both during and before the pandemic. For example, in July 2020 the police minister Bheki Cele announced that incidents of rape had increased by 706 cases compared to the same time last year. Cases of rape recorded a 1.7% increase, with over 53,000 cases in 2020 alone. And police detected 1,638 more sexual offences than the previous year.[20]

1.4.2. Despite this acknowledgement and numerous promises to take concrete steps against violence against women, including through the National Strategic Plan to address gender-based violence and femicide, serious failures continue to be apparent in the government's response to provide necessary funding for shelters and other services for survivors of violence.

1.4.3. Covid-19 lockdowns have had various immediate, medium- and long-term dire consequences, increasing the risk of gender-based and domestic violence against women and girls. Research by Human Rights Watch alludes to certain categories of persons being disproportionately affected. These persons include additionally marginalised because of their intersectionality, black lesbians, transgender women and men, sex workers, older women, asylum seekers, refugees, and undocumented migrants.

1.4.4. The covid-19 pandemic has had the greatest impact on certain marginalised groups in that sex workers specifically were forced to leave brothels, leaving them in a significantly vulnerable position and exposed to abuse and violence. [21]

1.4.5. Researchers have indicated that Covid-19 lockdown has caused a rise in GBV in that it "effectively made it easier for perpetrators to torment their victims with little or no room for support services".

1.4.6. This is substantiated by researched data collected by support call centres which showed that more than 12 000 victims were recorded in the first three weeks of the lockdown by the government GBV and femicide command centre alone. In Tshwane alone between 500 and 1 000 calls, a day was recorded by mid-April of 2020. Furthermore,

[20] https://ewn.co.za/2020/12/29/sa-s-second-pandemic-of-2020-gender-based-violence

[21] Human Rights Watch "South Africa Broken Promises to Aid Gender-based violence survivors" available at https://www.hrw.org/news/2021/11/24/south-africa-broken-promises-aid-gender-based-violence-survivors (accessed 13 January 2021)

during 2020 Vodacom's support centres recorded a 65% rise in calls "from women and children confined in their homes seeking urgent help" after the lockdown was started.[22]

1.4.7. Crime statistics from cases reported to SAPS from the 1st of July 2021 to the 30th of September 2021/2022 financial year (in a state where the country was under lockdown levels 4,3, and 2) revealed a 20.7 increase in murder recorded as compared to the previous normal period (2019/2020 financial year) with no lockdown, the murder percentage change would have been 13.2% increase.

1.4.8. According to data provided by SAPS 1 334 murders occurred at the home of the victim or perpetrator, and from a sample of 5 176 cases, there was a total of 2 424 people who were murdered in public places such as streets, open fields, parking areas and abandoned buildings.

1.4.9. Additionally, 9 556 people were raped between July and September 2021, this is an increase of 634 cases, 7.1% increase compared to the previous reporting period. From a sample of 6 144 rape cases, 3 951 incidents took place at the home of the victim or perpetrator, with 400 rape reported cases being domestic violence-related, i.e., that the victim and the perpetrator have a relationship. Moreover, in 19 of the top 30 police stations reporting the highest levels of sexual assaults, there was an increase as compared to the previous year over the same time.[23]

1.4.10. Analysis of the data of reported cases during lockdown compared to previous reporting periods suggest that there was not necessarily a decrease in GBV overall, rather than in the context of covid-19 lockdown, the degree to which victims are reporting offences may have been impacted. SAPS data shows a drastic increase in reported crime overall, including contact crimes (e.g., crimes ranging from murder to sexual offences to robbery and related crimes etc.) when lockdown restrictions were lifted. In June 2020, as South Africa implemented lockdown level 3 there was a surge in brutal femicide cases.

1.4.11. Unfortunately, the SAPS statistics depicted above fail to provide statistics through a gendered lens, however, it has been noted by Police Minister General Bheki Cele that with almost 10 thousand people being brutalized and sexually violated in just three months in South Africa, most people raped were women.[24]

2. **Please describe whether the legal framework prohibits and sanctions these forms of violence and the definitions and forms of violence included in the legal system. Please explain redress options for survivors of violence, (the pathway they go through if they decide to file a complaint), levels of impunity and if access to comprehensive physical and mental care for GBV-survivors is recognized as a form of reparation.**

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[22] Times Live's "Shocking stats on gender-based violence during lockdown revealed" available at https://www.timeslive.co.za/news/south-africa/2020-09-01-shocking-stats-on-gender-based-violence-during-lockdown-revealed/ (Accessed 13 January 2021);News24's "Change what South African men think of women to combat their violent behaviour" available at https://www.news24.com/w24/selfcare/wellness/mind/change-what-south-african-men-think-of-women-to-combat-their-violent-behaviour-20211005 (accessed 14 January)

[23]

[24] South African Police Services (SAPS) Speaking notes delivered by Police Minister General Bheki Cele (MP) at the occasion of the release of the Quarter Two Crime Statistics 2021/2022 hosted in Pretoria, Gauteng, on Friday 19 November 2021 available at https://www.saps.gov.za/newsroom/msspeechdetail.php?nid=36418 (accessed 14 January 2021)

2.1. Section 7(2) of the Constitution of South Africa requires the State to protect, promote and fulfil the rights in the Bill of Rights. In the context of violence against women, the following rights are directly implicated and obligate the state to act and protect women from violence:

2.1.1 *the right to equal protection and benefit of the law, including substantive.*

2.1.2 the right to inherent dignity and the right to have one's dignity respected and protected.

2.1.3 the right to life.

2.1.4 the right to freedom and security of the person, which includes the right to be free from all forms of violence from either public or private sources, and

2.1.5 the right to bodily and psychological integrity, which includes the right to security in and control over their body.

2.2. These sections impose both a negative obligation on the State not to interfere with rights and a positive obligation to take steps to respect, promote and fulfil rights.[25] There are several specific aspects of the state's duty that are now well-entrenched in the South Africa constitutional jurisprudence:

2.2.1 The state is obliged "*directly to protect the right of everyone to be free from private or domestic violence*";[26]

2.2.2 The state is obliged to "*take appropriate steps to reduce violence in public and private life*";[27]

2.2.3 The state is also obliged in certain circumstances "*to provide appropriate protection to* everyone *through laws and structures designed to afford such protection*" which may imply "*a positive obligation on the authorities to take preventative operational measures to protect an individual whose life is at risk from the criminal acts of another individual*".[28]

2.3. The Domestic Violence Act 116 of 1998 prohibits domestic violence against any person in a domestic relationship with the abuser meaning that it applies to opposite-sex and gender couples married and unmarried, same-sex and same-gender couples married and unmarried, between parents and children and any other types of domestic relationships.

2.4. The preamble of the Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2017 recognises the prevalence of sexual offences in South Africa and the vulnerability of women and children to these offences. The definition of rape in this Act has been provided in a manner that covers any person who is sexually penetrated without their consent. It goes beyond the penetration of the vagina and includes other forms of penetration with fingers or tongue.

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[25] *S v Baloyi (Minister of Justice and Another Intervening) 2000 (2) SA 425 (CC) at* para 11; *Christian Education SA v Minister of Education* 2000 (4) SA 757 (CC) at para 47; *Carmichele v Minister of Safety and Security* 2001(4) SA 938 (CC) at paras 44 to 45; *Minister of Safety and Security v Van Duivenboden* 2002 (6) SA 431 (SCA) at para 20.

[26] *Baloyi* 2000 at para 11.

[27] *Christian Education at* para 47.

[28] *Carmichele at* paras 44 to 45, citing with approval, *Osman v United Kingdom* 29 EHHR 245 at 305, para 115.

2.5. In terms of the Employment Equity Act 55 of 1998, harassment of an employee is a form of unfair discrimination, and it is prohibited on any one or combination of grounds of unfair discrimination listed in the Act. Sexual harassment is a form of unfair discrimination based on the grounds of sex, gender and/or sexual orientation. In addition to the criminal sanctions, it can also be pursued as unfair discrimination.

2.6. The Protection from Harassment Act 17 of 2011 is a law that provides victims of harassment with a way to protect their rights against harassment. It introduces procedures that help the courts, and the police protect the rights of victims of harassment.

3. **Please share examples of the types of structural and institutional violence with origins within the State, (perpetrated or condoned by the State) or perpetrated by those not representing or affiliated to the state in your country/ies of the region, and who is affected. In particular, describe structural/institutional violence in medical settings against women and girls, LGBTI persons and persons with disabilities or any other individuals or groups relevant in your country/ies or regions.**

A. Forced and coerced Sterilisation of Women Living with HIV in South Africa

3.1 In our experience, most responses to human rights violations are seldom done by the state and/or the relevant duty bearers on their own accord. We discuss the experiences of black women who are being sterilised here and how the state responded.

3.2 Our work representing women living with HIV who have been sterilised indicate that sterilisations occurred as far back as 1995 with the latest case occurring in 2021. The reports of women living with HIV being sterilised without their consent was often disregarded by the Department in favour of a patriarchal and paternalistic approach that posits that the Department knows what is best for them and how to deal with their pain. This often left them without any access to justice and with poor health outcomes too.

3.3 Survivors often have the burden of forcing the state and other role players to respond to their rights violations. In this instance, it took survivors approaching lawyers seeking relief and lodging a complaint with the Commission for Gender Equality, a constitutionally established state body responsible for promoting and advancing gender equality in South Africa.

3.4 In a report dated February 2020,[29] the CGE found that the rights of women who lodged a complaint with them had been violated. The rights violated included the rights to equality; dignity; bodily integrity and freedom and security over their bodies; and the right to the highest attainable standards of health including sexual and reproductive rights. The CGE found that:

- Complainants were not provided adequate information on the sterilisation procedure before their consent was obtained;
- Complainants were not advised of alternative methods of contraception;
- They were subjected to cruel, torturous, or inhuman and degrading treatment;
- The medical staff breached their duty of care towards the complainants; and
- The consent forms produced in some of the cases were not indicative of informed consent.

[29] Commission for Gender Equality, *Investigative Report: Forced Sterilisation of Women Living with HIV and Aids in South Africa* February 2020, accessible at: http://www.cge.org.za/wp-content/uploads/2016/12/Forced-Sterilisation-Report.pdf. The investigative report was released in February 2020 and investigated the practice of forced sterilisation of women living with HIV/AIDS following a complaint lodged in March 2015 by HRI and others represented by the WLC. The complaint documented the accounts of 48 women who had experienced forced or coerced sterilisation.

3.5 Black, pregnant, women living with HIV from lower-income families and communities, who rely solely on state-funded healthcare were targeted. The intersection of their identities rendered them more vulnerable to forced and coerced sterilisation than any other group of women in South Africa.[30]

3.6 Victims of involuntary sterilisation have reported experiencing negative psychological symptoms most notably those related to anxiety, stress, and depressive symptoms.[31] Many victims have also reported multiple physical or negative health effects (complications) as a side effect of the sterilization surgery.[32]

3.7 Generally, and especially in Africa, a woman's ability to bear children is closely linked to her worth and essential identity as a woman. The inability to bear children due to being sterilised, willingly or not, is seen as a failure. It renders women as valueless and undesirable for men as reproduction is considered an essential component of any relationship.[33] The social, cultural, and gendered pressure on women to bear children inevitably implicates their self-worth and dignity.[34]

3.8 Women continue to face multiple very nuanced forms of violence mainly from their partners. For many women sterilisation and the inability to have children has increased their risk of violence as many women represented by WLC and HRI have exemplified.

3.9 As we have also stated above, these women also receive limited solidarity from family members and their community as the inability to have children, impacts a woman's sense of worth to the family and is considered to bring humiliation to families. This again increases their risk to violence.

B. Institutional violence against transgender, gender diverse and intersex persons

3.10 By expressing greater bodily and gender diversity than 'allowed' within socially constructed stereotypes and presentations of men and women, LGBTQI+ persons are exposed to stigma, harassment, and sexual and physical violence at the hands of family members, their communities, and State actors. *Not only does this violence deprive them of basic human rights, it increases their risk for HIV, mental health problems, and poverty*."[35]

3.11 Transgender persons have reported twice as much bullying from teachers and students alike than cisgender persons; these statistics contribute to high levels of truancy, absenteeism, decreased educational aspirations and lower academic performance and ultimately lead to lower economic and social standards of living in later life. Transgender people also find it difficult to access legal protection through law enforcement.

3.12 Not only does this deprive them of their basic human rights, but it also increases their risk of poverty, HIV infection and other health-related problems, as well as their access to rights such as legal citizenship and education. Further, many transgender persons continue to report difficulty in accessing necessary health services, particularly friendly and affirming healthcare, even in the aftermath of sexual and physical violence.

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[30] Strode, Mthembu & Essack (2012) Reproductive Health Matters 63;

[31] Mnguni *Report on forced sterilization*; K Bakare & S Gentz "Experiences of forced sterilisation and coercion to sterilise among women living with HIV (WLHIV) in Namibia: an analysis of the psychological and socio-cultural effect" (2020) *Sexual and Reproductive Health Matters* 339.

[32] Mnguni *Report on forced sterilization*; Bakare & Gentz (2020) *Sexual and Reproductive Health Matters* 340.

[33] M du Toit "Involuntary sterilisation of HIV-positive women in South Africa: A current legal perspective" (2018) 11 SAJBL.

[34] du Toit (2018) SAJBL 1.

[35] Kate Giles, 'Gender-Based Violence Against the Transgender Community Is Underreported' available at http://www.prb.org/Publications/Articles/2011/gender-based-violence-transgender.aspx

3.13 Statistics of reported crimes are not broken down into subcategories to focus on forms of violence and discrimination based on sexual orientation, gender identity, gender expression or sex characteristics. Further, the Stat SA, the national statistics service, VOCS reflect those statistics on a specific crime are collected only from a binary breakdown of information, i.e., the indicator 'sex' being either Male or Female.[36]

3.14 When evaluating the state's collection of data, one finds that diverse sexual orientation, gender identity and expression and sex characteristics are excluded from the main and largest crime reports in South Africa.

3.15 These findings relating to data disaggregated statistics were echoed by the United Nations Special Rapporteur on violence against women, its cause, and consequences. After a country mission, she expressed concern about data collection pertaining to violence against women. She recommended that the state expand the collection of data to all forms of violence which includes violence against women and all other types of sexual offences under the Sexual Offences Act (SOA). She also noted that data should include details on the indicators of sex, age, sexual orientation, disability and importantly the relationship between the perpetrator and the victim.[37]

4. **Please also share information on the impact of criminalization of sex work, same-sex relations, transgender persons, abortion, drug abuse, harmful practices in obstetric care, female genital mutilation on the violence experienced by the affected individuals and their enjoyment of the right to health.**

Impact of criminalisation of sex work on violence against affected women

The criminalisation of sex work increases sex workers' exposure to violence as it contributes to perpetuating and reinforcing stigma and discrimination against female sex workers disproportionately affecting them as a marginalised group.[38] This is exacerbated by the difficulty to report violations perpetrated against them due to fear and societal discrimination.[39]

Strikingly, the criminalization of sex work and inappropriate regulation are core factors which drive sex workers underground, decreasing their access to justice while increasing their likelihood of facing violence.[40]

A. The impact of Criminalisation on sex workers' health care:

4.1. The criminalisation of sex work has significantly hindered sex workers access to health care in South Africa. Research by the Sex Workers Education and Advocacy Taskforce SWEAT has shown that criminalisation of sex work discourages sex workers from seeking health/medical care because of the stigma that is associated with sex work and their fear of being arrested. Evidently, heightened stigma and secondary victimisation have been noted to prevent sex workers from seeking health care in instances where they have been raped.

[36] Governance, public safety, and justice survey GPSJS 2019/20 statistical release. Available at: http://www.statssa.gov.za/publications/P0340/P03402020.pdf

[37] UN Human Rights Council, *Report of the Special Rapporteur on violence against women, its causes and consequences on her mission to South Africa*, 14 June 2016, A/HRC/32/42/Add.2, available at: https://www.refworld.org/docid/57d90a4b4.html [accessed 5 March 2021]

[38] *Jordan and others v S* 2002 (6) SA 642 (CC) para 8.

[39] Sanger, C 2020 4.

[40] Jewkes, R., Otwombe, K., Dunkle, K., Milovanovic, M., Hlongwane, K., Jaffer, M., Matuludi, M., Mbowane, V., Hopkins, K.L., Hill, N. and Gray, G., 2021. Sexual IPV and non-partner rape of female sex workers: Findings of a cross-sectional community-centric national study in South Africa. *SSM-mental health*, *1*, p.100012.

4.2. The fear of abuse, arrest, and discrimination many sex workers experience because they have been refused treatment from medical practitioners and staff, given inadequate treatment or ridiculed because of their work means that they have poor access to:

- HIV prevention and treatment.
- Post-exposure prophylaxis after being raped.
- Emergency contraceptives.
- Treatment of sexually transmitted infections and diseases.
- Drug treatment and other harm reduction services[41]

4.3 In addition, practices by police, such as profiling sex workers as well as searching them for condoms as evidence of prostitution may cause women sex workers to not carry or use these safeguards.[42] It has also been reported by health care workers that sex workers are reluctant to accept condoms in large numbers because it makes them a target for police officers.

4.4 The SWEAT report details the arrest and detention of peer educators from key clinics as one of their primary challenges because essential resources allocated for clinics and other medical NGO'S must be used to free peer educators and sex workers. Police detention for days on end has been reported to limit sex workers access to vital medication such as ARV's for women sex workers living with HIV.

B. Human Rights violations by Police against sex workers in South Africa under criminalisation:

4.5 Our research has shown that the criminalization of sex work cultivates conditions where abuse and exploitation can thrive, rather than the eradication of sex work for which it is intended, its impact is an unhealthy and unregulated environment where sex workers suffer systemic violence and rape. As most sex workers in South Africa are female, when one considers the high statistics of gender-based violence as alluded to earlier in this submission, the conditions enabling violence against sex workers are compounded.[43]

4.6 Of the most common violations impacting the physical and emotional well-being of sex are human rights violations by police officials against sex workers. Sex workers have shared experiences of suffering immense violence by police officials. Instances where they have been pepper-sprayed during arrests; assaulted publicly at police stations and refused reasons when they request reasons for their arrest from police officers.

4.7 One female sex worker from Cape Town describes an instance where the police picked her up from one of the corners and told her that they were taking her to the police station, however instead of taking her to the police station, the police wanted sexual favours from her, and she was not able to identify them because both were not wearing their name tags. This is one example of the way in which sex workers have no way to identify them and police officers instil such fear that sex workers are afraid to report crimes perpetrated against them to the very people committing those violations.[44]

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[41] Women's Legal Centre (2012) Stop Harassing Us! Tackle Real Crime! A report on Human Rights Violations by Police Against Sex Workers in South Africa, WLC, SWEAT and Sisonke

[42] Human Rights Watch 'Why sex work should be decriminalised in South Africa' (2019)

[43] SWEAT "Say Her Name Report" available at http://www.sweat.org.za/wp-content/uploads/2019/08/Sweat-Say-Her-Name-Report_HI-RES.pdf (accessed on 15 January 2022); a 2013 study concluded that approximately 167 000 out of 182 000 sex workers in South Africa were female substantiating that the majority of sex workers are and continue to be female, while there are clients male; Sanger, C "*S v Mthethwa*: Justice for sex workers in the face of criminalisation?" 2020 *Agenda: Empowering women for gender equity* 4.

[44] Women's Legal Centre (2012) Stop Harassing Us! Tackle Real Crime! A report on Human Rights Violations by Police Against Sex Workers in South Africa, WLC, SWEAT and Sisonke 12.

Likewise, one study in Cape Town shows that approximately 12% of sex workers street-based had been raped by police officials.[45]

4.8 Human Rights Watch interviews with sex workers concluded that arrests of sex workers are seemingly almost always because of police profiling rather than actual observed illegal activity. They found that all interviewees who had been arrested said that they had been arrested because they were standing in areas known to be a hotspot and thus targeted by SAPS. Furthermore, sex workers believe that in some cases they were arrested because their faces were known by police.[46] A recent research study published in 2021 on intimate partner violence and non-partner rape of female sex workers concluded that police abuse is a consistent pattern recurring in research on violence against female sex workers.[47]

4.9 The high prevalence of police violence targeted against sex workers in certain geographical areas indicate a systemic problem. Additionally, considering statistics of structural risk factors such as age, relationship status, migration, education level, food security, childhood and other trauma, and work circumstances, show that gender norms around patriarchal privilege and sexual entitlement contribute to violence particularly because regions in South Africa with the highest pervasiveness also constituted areas with high levels of violence perpetrated by clients and other men.[48] It is therefore a key finding in their research that there is a dire need for effective management of police services and sensitization training to safeguard sex workers against the abuse of power by police with impunity and ensure accountability

4.10 Their analysis highlighted that at the core of change in the lived realities of female sex workers and the conditions enabling violence against them lies legislative change to strengthen protection of sex worker's rights. .

4.11 There is a need for the reinforcing of outreach programs in relation to sex workers in South Africa as well as providing more sex workers with opportunities for collective action, to improve each other's safety by working indoors.[49]

4.12 Evidently, research suggests that there is a direct nexus between the need for and importance of legislative reform and decreasing sex worker's exposure to violence in addition to reducing impunity for perpetrators.

a. Access to abortion and violence

4.13 The right to have an abortion is constitutionally protected by the guarantee of the rights to bodily autonomy and reproductive health. Sometimes this decision is based on women and girls' individual social or economic life circumstances.[50] Further, high rates of sexual violence in South Africa, as well as unpredictable health and life risks in pregnancy and the possibility of severe foetal abnormalities, mean that no matter how well fertility management services and information are implemented, there will always be a need to ensure access to abortion services.[51] Despite this need, the voluntary termination of pregnancy is perceived as immoral by certain sectors of the South African society. These social perceptions and attitudes contribute towards the stigma attached to the termination of

[45] https://asijiki.org.za/wp-content/uploads/Position-Paper-on-Sex-Work-in-South-Africa.pdf

[46] Human Rights Watch 'Why sex work should be decriminalised in South Africa' (2019) 34.

[47] Jewkes, R et al (2021) Sexual IPV and non-partner rape of female sex workers: Findings of a cross-sectional community-centric national study in South Africa. *SSM-mental health*, 6.

[48] Jewkes, R et al (2021) Sexual IPV and non-partner rape of female sex workers: Findings of a cross-sectional community-centric national study in South Africa. *SSM-mental health*, 5,6.

[49] Jewkes, R et al (2021) Sexual IPV and non-partner rape of female sex workers: Findings of a cross-sectional community-centric national study in South Africa. *SSM-mental health*, 7.

[50] Amnesty International

[51] Amnesty International

pregnancies and act as a barrier to access to safe and legal abortions, particularly where these views are held by health care practitioners.

4.14 Medical practitioners allow their personal anti-abortion beliefs to influence the way they interact with patients. For example, they may, in seeking to persuade women not to terminate their pregnancies, show them visual representations of the foetus' stage of development, describe the foetus as a "baby" and the patient as a "mother" to ascribe personhood to the foetus and seek to persuade pregnant mothers that they will not be able to cope with the guilt of terminating their pregnancies. This exacerbates the stigma associated with abortion and forces many women to seek services outside of lawful terminations of pregnancy. This has detrimental effects on the lives of the pregnant who must endure this mental and physical violence and, in some instances, forced to become mothers when they did not want to.

4.15 The Amnesty report recorded that approximately 83% of South Africans rely on the public health care system. Of the 3 880 public health care facilities, including 318 hospitals, only 214 health care facilities provided termination of pregnancy services. Most of these are in urban areas, and nearly half of the clinics and about 20% of the 238 Community Health centres reported having no access to doctors who are authorised to provide abortion services. Given the limited number of facilities offering abortion services and the stigma that attaches to approaching these services, many women are forced to seek these services outside the legal abortion services infrastructure. This increases the risk of complications arising from abortion, as well as the risk of death, thereby increasing the maternal mortality rate.

b. Harmful practices in obstetric care in South Africa

4.16 Several reports and research projects have supported raising concerns over the quality-of-care birthing women in the public maternal health sector are being subjected to.[52] These concerns are not new and have been documented by researchers in South Africa for more than a decade. Research conducted on the topic has highlighted problems of neglect, verbal and physical abuse and a lack of informed consent and accountability. Problems that can be largely classified as obstetric violence.

4.17 Behaviours that have fallen under the academic term "obstetric violence" include neglect; verbal and emotional abuse; physical abuse; sexual abuse; racism, classism, ableism, and cultural violence throughout doctor-patient interactions; lack of confidential and consensual care; and the inappropriate, non-evidence-based use of medical interventions, including routine episiotomies, routine inductions, preventing labour companions, and unnecessary caesarean sections ("c-sections").[53]

4.18 Obstetric violence is a form of medical malpractice that primarily affects bodies that can carry and deliver children. This means that obstetric violence is an exclusively gendered form of medical malpractice that primarily affects women and girls. Marginalized and impoverished women and girls are particularly vulnerable to such violence as it has been in the poorer public hospitals serving the racially and economically marginalized female population of South Africa, where the most frequent and rampant reports of obstetric violence have been observed.[54]

4.19 It is very easy to draw parallels between the mistreatment of women in childbirth and violence against women more broadly, and it is encouraged that obstetric violence should be viewed as a

[52] R Chadwick *The Right To Dignity In Childbirth? Public Sector Birth Narratives* Postdoctoral Research Report (2013)

[53] RJ Chadwick "Obstetric violence in South Africa" (2016) 106 *South African Medical Journal* 423 24.

[54] S Bradley, C McCourt, J Rayment, D Parmar "Disrespectful intrapartum care during facility-based delivery in sub-Saharan Africa: A qualitative systematic review and thematic synthesis of women's perceptions and experiences" (2016) 169 *Social Science & Medicine* 157 70.

further subcategory of violence against women. Violence against women stems from structural gender inequality (women's subordinate position in society). This subordinate position allows for the systematic devaluation of the lives of women and girls and accordingly enables the allowance of inappropriately low allocation of resources and accountability measures in maternity care. The enabling structural gender inequality also disempowers women and enables the use of violence against them.[55] In essence, as the physical, verbal, and sexual abuse of women and girls in South Africa has become so commonplace, medical providers and the state too frequently dismiss and or minimize the experiences of obstetric violence victims.

The experience of women who have been victims of obstetric violence reflect troubling human rights violations and while childbirth might be seen by some as a minute, limited event without a great deal of significance, research has shown that traumatic birth experiences can have a substantial and long-term effect on a women's psychological health and the mother-infant relationship.

South African women's experiences of obstetric violence

4.20 In South Africa, the maternal mortality rate (MMR) has not significantly decreased between 2010 (625 /100,000 births) and 2016 (536 /100,000 births). This is particularly surprising for a developing country where access to maternal health services is reported at an estimated 96% of women giving birth in a health facility, with antenatal care coverage at 94% and 84% of mothers returning for postnatal care.

4.21 Direct causes (e.g., hypertension, maternal haemorrhage, maternal sepsis, and obstructed labour) make up more than half of the maternal deaths in South Africa.[56] These are causes that should be preventable for women who have access to contemporary medical technologies. Of the preventable and direct causes of maternal deaths, obstetric causes make up a large proportion of these deaths. In the years between 1999 and 2001, over half of maternal deaths in South Africa (and 75% at the primary care level) were reported to be linked to avoidable factors stemming from uncertain health worker practices.

4.22 The most extreme reports of obstetric violence have been cited from public state-funded hospitals with women across the country having cited experiencing neglect; verbal and emotional abuse; physical abuse; racism, classism, and cultural violence; a lack of confidential and consensual care; and the inappropriate, non-evidence-based use of medical interventions, including routine episiotomies, routine inductions, preventing labour companions, and unnecessary caesarean sections.

4.23 Reports have found that violence has become institutionally normalised due to a lack of accountability and action by managers, dysfunctional or absent mechanisms of complaint, an underlying ideology of patient inferiority and professional sanctioning of coercive behaviours.

4.24 According to the birth narratives of many South African women, nurses have been described as 'inhuman', lacking in caring and using verbal abuse and threats of physical violence to control patients. Women have reported feeling afraid of nurses and have narrated these reports as the most distressing part of their birth experiences.

4.25 Another way in which obstetric violence manifests itself is in the inappropriate provision of medical care, which in turn contribute to avoidable maternal deaths, malpractice suits and risky health facility practices.

[55] R Jewkes, L Penn-Kekana "Mistreatment of Women in Childbirth: Time for Action on This Important Dimension of Violence against Women" (2015) 12 PLoS Med.

[56] NJ Bomela "Maternal mortality by socio-demographic characteristics and cause of death in South Africa: 2007–2015" (2020) 157 BMC *Public Health.*

4.26 Unnecessary c-sections are of particular concern as they have contributed to South Africa's worsening MMR, have led to several reports of medical malpractice, and broadened the occurrences of risky health facility practices. The caesarean section rate for South Africa is (24%)[57], and although provincial averages differ, all are above the minimum recommended by the World Health Organization (15%).[58]

4.27 Of further concern are the numerous reports of women being denied access to pain killers and being operated on without pain management. Although denying women access to pain relief in labour/birth has been identified as a form of physical abuse, women birthing in the public sector in South Africa are routinely denied pain relief and have been denied humane and woman-centred intrapartum care.[59]

4.28 Further inappropriate provisions of medical care have also included Augmentation of labour using vaginal prostaglandin tablets; the provision of Intravenous Buscopan for poor progress in labour, often without a prescription; Fundal pressure in the second stage of labour; The use of 50% dextrose water intravenously for neonatal and maternal resuscitation; Routine rectal enemas on admission; Lack of nutrition during labour; and the Passive management of the third stage of labour.

Prevalence among marginalized women.

4.29 The notion of the 'good patient' versus the 'difficult (or bad) patient' has been playing a vital part in further victimizing vulnerable groups of women in the South African public health contexts and more specifically in maternal health and intrapartum care.

4.30 Studies conducted on nurses have found that to South African nurses, 'good patients' were to be friendly, obedient, polite, undemanding and clean while 'bad' patients were noted to be rude, aggressive, uncooperative and demanding.[60]

4.31 In this system based on societal norms and enforced by nurses, good patients are rewarded with care while 'bad' or 'difficult' patients are often ignored, verbally or physically abused, and neglected.

4.32 Although on the surface a seemingly harmless differentiation, this practice has left marginalized women even more so vulnerable to obstetric violence as it would be much harder for these groups of women to construct a 'good patient' identity when social markers such as age, poverty, race, sexuality, marital status, and ethnicity often automatically position some as 'bad' or 'difficult' patients. For example, being a pregnant teenager is often enough to mark certain female patients as 'deviant', poverty-stricken women are shamed for their lack of resources and are judged as morally and intellectually inferior. Accordingly, social inequalities leave marginalized women even more so vulnerable in the obstetric context. Those marginalized groups include adolescents, poor women, foreigners, HIV positive women and differently-abled women.

4.33 A women's race, poverty or status accordingly overtly influences the timeliness and quality of care they will receive. Women deemed 'modern' or 'worthy' often receive preferential treatment and deliberate decisions are made to actively withhold, neglect, or ignore women deemed to be outside those categories.

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[57] South Africa Demographic and Health Survey 2016: Maternal Health Care 127

[58] Human Rights *Watch Stop Making Excuses: Accountability for Maternal Health Care in South Africa* (2011).

[59] E Farrell and RC Pattinson "Out of the mouths of babes — innocent reporting of harmful labour ward practices" (2004) 94 *SAMJ*.

[60] R Jewkes, N Abrahams & Z Mvo "Why Do Nurses Abuse Patients? Reflections From South African Obstetric Services" (1998) 47 *Social Science Medical* 1781 1795.

Causes of obstetric violence

4.34 Various sources have been cited to explain the rampant occurrences of obstetric violence in South Africa's public health care system. Researchers have identified systematic problems, a lack of accountability mechanisms and enforcement thereof, resource constraints, emergency transport problems, and problems with the supervision of maternity staff as the leading contributors. Researchers have also identified that many medical staff are not given adequate training in birthing complications and treatments, are underpaid, are overworked and work in conditions that lead them to lash out at or have limited patience with patients.

4.35 The state has established the National Committee on Confidential Enquiries into Maternal Deaths (NCCEMD). The NCCEMD is a regulatory body that aims to obtain data for all maternal deaths and to capture causes, avoidable factors and substandard care related to every death to identify trends and areas for improvement.

4.35.1 While the confidential enquiry into maternal deaths (CEMD) system in South Africa has been very useful in describing the causes of maternal death, both pathological and health system failures, and for suggesting effective interventions which were adopted in the National Department of Health. Unfortunately, the NCCEMD does not have budget and is in the NDOH directorate (Women's Health) which does not have much power or resources. Further, the NCCEMD is not able to collect all the maternal deaths that occur at home.

4.35.2 The NCEEMD has noted in its own report that it has made 10 Key Recommendations in each of the last four reports. The recommendations remained essentially the same for all the reports as the problems have also remained the same. The recommendations have in the past been sketchily implemented.[61]

5 <u>Please share information on the health and other type of responses provided by the State and/or other actors in your country/ies or regions in focus to survivors of each/some of the aforementioned forms of violence. Please assess what works well and not so well, and whether COVID-19 impacted the response and how.</u>

Nothing of survivors without survivors: Adopting a victim-centred approach and undoing the patterns of excluding certain women in decisions affecting them:

5.1 Most women that we represent have expressed concern when decisions that affect them are made without any prior engagement with them. For such women, the lack of prior engagement creates an impression that the women's views, experiences, and trauma are not important to the duty bearers or decision-makers.

Failure to address the Enabling Environment for sterilisation as created by the Sterilisation Act 44 of 1998

5.2 The Sterilisation Act, the legislation that regulates sterilisation in South Africa, does not provide enough protection to ensure that proper and informed consent is obtained. It has accordingly been recommended that the National Department of Health ('NDOH') review the provisions of this act and interrogate consent forms for sterilisations to ensure that they offer adequate and effective protection. [62]

[61] Saving Mothers Report - https://www.hst.org.za/publications/NonHST%20Publications/savingmothersshort.pdf

[62] Commission for Gender Equality *Investigative Report: Forced Sterilisation of Women Living with HIV and Aids in South Africa*.

5.3 The CGE, after concluding its investigation into forced and coerced sterilisations, has also concluded that it will submit a petition to amend all legislation regulating consent to the South African Law Reform Commission ('SALRC').

5.4 The CGE has also recommended that the report be referred to: The Health Professionals Council ('HPCSA'); The South Africa Nursing Council ('SANC'); The National Department of Health ('NDOH'); and The South African Law Reform Commission ('SALRC').

5.5 The HPCSA and SANC determine the standards of ethical and professional practice for registered health practitioners and have the power to institute disciplinary proceedings against a person registered with the Council in accordance with the rules set by the Professional Board. Thus far, however, neither of these bodies have taken any proactive steps in response to the CGE's recommendation. They have extended an invitation to women wishing to lay a complaint against specific health care personnel but unfortunately, this remedy depends on the complainant knowing the name and position of the person who violated their rights, and this is most often not the case in these complaints. Both organisations have not taken any remedial measures to ensure that the practice does not continue to be practised by medical practitioners.

5.6 The CGE has also recommended that the NDOH facilitate a dialogue with the complainants to find ways of providing redress for the complainants, among other recommendations. In response to this, the Minister of Health put together a Ministerial Task Team made up of medical professionals employed in the Department of Health and under the directorate of dealing with family planning services. The Task Teams mandate is to engage with women living with HIV/AIDS who have been forced and coerced into sterilisations in an appropriate response to the forced and coerced sterilization that took place in public hospitals. The establishment of the Task Team and their terms of reference is indicative of the fact that the Department of Health acknowledges that women were forced / coercively sterilized in public hospitals in South Africa and that they are willing to take steps to address the issue. The work of the Task Team is currently pending.

Limiting the ability of survivors of sterilisation to seek justice and redress: The Prescription Hurdle

5.5 Though there is no shortage of mechanisms available to women through Courts in South Africa, unfortunately, section 11 of the Prescription Act 68 of 1969 ('Prescription Act') limits women who have been sterilised, access to courts and civil claims as it only allows for the institution of claims within the 3 years after a victim is aware of their cause of action.

5.6 Most women who were forced/coerced sterilization were aware at a medical level that the procedure had been done or became aware shortly after but due to circumstances and language and terminology used to justify the procedure as necessary, commonplace and/or due processes, a lot of the women were unaware that the practice was done contrary to their constitutional rights and that legal recourse was available to them. Many of the cases dated before 2018 have accordingly prescribed.

5.7 The problem of a passage in time not only affects access to courts. This is likely to be a problem with all possible avenues available to women. Hospitals are only required to keep medical records for a minimum of 6 years[63] and with time some files may go missing and related personnel might pass or move on to other undisclosed locations making it difficult to acquire the information necessary to pursue reparations.

[63] HPCSA *Guidelines on the Keeping of Patient Records* (2016) 3.

5.8 The mechanisms available to women are not always utilised for several reasons. The contributing factors include: socio-economic inequalities that impact the provision of, and access to, adequate legal representation for the poor; systemic inefficiencies in the administration and functioning of the courts and government bodies, which leads to an inordinate number of postponements of cases and a loss of faith in the system; high demand for legal aid services which remain unmet by the current resource provision; a lack of access to information about the rights women have and the mechanisms available to protect and exercise these rights.[64]

Mechanisms for relief available to victims of obstetric violence

5.9 Effective individual complaint and redress mechanisms are a key element of accountability systems and contribute towards redressing past grievances and correcting systematic failures.[65]

5.10 Women need accessible, easily understood, and effective ways of lodging complaints about mistreatment suffered while accessing health services. This would improve the standards and trust placed in our public health care facilities. Accountability mechanisms are important for ensuring that the right to the highest attainable standard of health is being progressively realized.

5.11 Provincial and national laws recognize that patients have a right to a remedy if they experience abuse or mistreatment whilst in health facilities. Victims accordingly have the option of lodging complaints directly with the health establishment at which they experienced mistreatment, which would be in line with the National Health Act.[66] The complaints procedure should be publicly displayed within the health establishment so that users are aware of the applicable procedures, which makes provision for an escalation process for the complaint should it not be handled satisfactorily or be left unresolved.

5.12 Further, in accordance with the National Health Act, and Provincial Health regulations, health centres and clinics are to have "health committees" where communities can air their grievances about the quality of care they receive. Health care facilities are to also have quality assurance officers dedicated to handling complaints.

5.13 Complaints may also be directed to the Office of the Ombud within the Office of Health Standards Compliance ('OHSC'). The OHSC is established in terms of the National Health Act and is tasked with promoting the health and safety of users of health services in South Africa, and the Ombud may investigate complaints relating to inappropriate treatment or care; inappropriate behaviour by a healthcare facility; poor quality healthcare services provided by a healthcare establishment; and unsatisfactory management of a complaint by a healthcare establishment.

5.14 Other mechanisms include seeking accountability through litigation; or lodging a complaint with one of the Chapter 9 institutions established in terms of the Constitution, such as the CGE, Public Protector, or Human Rights Commission.

5.15 Though there is no shortage of mechanisms available to women, these are not always utilized for several reasons, including a lack of knowledge about individual rights, violations, and available avenues for relief in the case of such violation; lack of responsiveness from duty bearers or those receiving complaints; a culture of impunity and fear of reporting; and a lack of access to financial resources to pursue any avenues for recourse.

[64] L Greenbaum "Access to justice for all: a reality or unfulfilled expectations?" (2020) *De Jure Law Journal*.
[65] Human Rights *Watch Stop Making Excuses: Accountability for Maternal Health Care in South Africa* (2011).
[66] Section 18(3)(a) of the National Health Act 61 of 2003.

5.16 Researchers have also found issues with the relief mechanisms immediately available to women in the public health care sector. Due to a lack of resources and enforceability mechanisms, information on how to pursue relief is not made readily available to victimized women (i.e., There are no posters in place, any available posters are of no use to illiterate patients, suggestion boxes are defunct). Implemented relief mechanisms are not sufficiently enforced, are left to the very same overworked and underpaid nursing staff, and fail to address the root problems and bring about systematic changes. And lastly, due to a lack of resources, several mechanisms have been undermined and rendered dysfunctional due to understaffing and the lack of supervising bodies.

5.17 In relation to the role COVID 19 has played in access to these mechanisms, it has only added more strain to an already broken system.

5.18 COVID 19 has had a massive impact on overwhelming public health care facilities and has severely undermined facilities which had previously already been unable to accommodate the large populations of women they were responsible for.

5.19 Many more women were and still are now more vulnerable during the pandemic as due to covid regulations, access to birthing companions and partners has been even further frustrated. This has meant that women no longer have access to the protection provided by birthing companions/partners and have been left vulnerable to obstetric violence.

5.20 Relief mechanisms have also been rendered even more so inaccessible as more state offices are having to close regularly in compliance with covid regulations or have implemented operating systems that work to the disadvantage of those seeking relief (i.e., hybrid or rotational working schedules that mean some officials are now only accessible via email or on every 2nd or 3rd day which is to the disadvantage of impoverished women without access to technology or the resources necessary to travel to and from in accordance the state rotational schedules in place that month).

6 <u>Please describe the needs of survivors of the above mentioned forms of violence as identified by your State/institution. Please share survivor-self identified needs and those of their families, with a focus on health emergency and long-term needs.</u>

Survivor Identified Needs of women sterilised because of their HIV status that are represented by the Women's Legal Centre

7.1. Our work representing over 80 women who were sterilised has documented the following as the key responses that these women are seeking from the state:

7.1.1. public acknowledgement that their rights have been violated by the state because they are poor black women living with HIV/AIDS;

7.1.2. recognition that there was/is state-sanctioned sterilisation of poor black women living with HIV/AIDS informed by the need to control the fertility of such women;

7.1.3. that all women who were forced / coercively sterilized should be able to seek recourse against the state and that a special mechanism needs to be set up to deal with and address women's cases beyond those before court;

7.1.4. that women should be entitled to remedial medical processes where this is an option, and that counselling and mental wellness support should be made available to them at the cost of the state with a consideration of those who caused them harm cannot counsel them;

7.1.5. that a fund be established where women would be able to receive financial compensation/restitution for the harm that they suffered;

7.1.6. that the Department of Health be instructed to implement processes and procedures to ensure that no women are forcibly / coercively sterilized in South Africa because of their HIV/AIDS status;

7.1.7. that the Sterilisation Act be amended to ensure that the practice, processes are put in place to ensure that forced/coerced sterilization of women living with HIV/AIDS is unequivocally prohibited and further regulations on forced and coerced sterilisation are done with oversight, reporting, monitoring in a manner that protects rights of women targeted by such practice and which is consistent with some of the developments of this issue internationally;

7.1.8. lastly, that, because most women experienced the procedure during the height of AIDS denialism in South Africa, the Prescription Act should be declared unconstitutional in so far that it might restrict women's constitutional right to recourse in respect of the human rights violations that they have suffered.

The identified needs of obstetric violence victims

7.1.9. From the research reports geared at collating the experiences of obstetric violence victims, the following was emphasised by the women involved;

7.1.10. Victims have expressed the need for accessible, easily understood, and effective ways to lodge complaints about mistreatment suffered while accessing health services. This would improve the standards and trust placed in our public health care facilities and is important for ensuring that the right to the highest attainable standard of health is being progressively realized.

7.1.11. Victims have also advised that the shortcomings of the public health care system, which have allowed for such victimisation to continue, need to be addressed and remedied to ensure that systematic changes are implemented and not just superficial remedies.

7.1.12. In most reports victims were often reluctant to place the blame entirely on the nursing staff, a profession mainly made of black women and had rather cited structural issues such as underfunding and a lack of resources as a barrier to reform.

7.1.13. Victims have also taken issue with the structural and societal norms that have allowed for such violations to continue and have expressed that more awareness and advocacy campaigns were necessary to both bring light to this issue and to aid other victims.

8. Question 8 and 9:
Please share examples of good practices and examples of comprehensive health responses to survivors of violence and indicate efficient multi-sectoral efforts at the community, national, regional and international levels by State or non-State actors.

Please describe State and other actors initiatives and measures to prevent these forms of violence, specific budget allocated to prevention, and good practices in this regard.

8.1 Specialised Police services that focus on Family Violence, Child Protection, and Sexual Offences Unit ("FCS" Units): The focus of the FCS Units is to provide a sensitive, professional service

endearing to the victims of family violence, children, seeking protection and sexual offences and investigation such offences.

8.2 The Thuthuzela Care Centres utilised in South Africa

8.2.1 In 2000 Cabinet instructed the Heads of the Departments of Social Development and Health to develop the Anti Rape Strategy as a response to the alarming rape statistics. In 2002 this process was transferred to the Department of Justice and Constitutional Development.

8.2.2 The Interdepartmental Management Team (IDMT) was formed under the leadership of the Department of Justice and Constitutional Development and comprised of representatives of the following national departments: Justice and Constitutional Development (as it then was), Health, Social Development, Safety and Security (as it then was), Correctional Services (as it then was), Education Treasury and Government Communication and Information System (GCIS).

8.2.3 As one of the initiatives to address rape care management the IDMT developed the Thuthuzela Centre model. In isiXhosa Thuthuzela means "to comfort".

8.2.4 The Thuthuzela Centre model represents a radical approach to rape care management, with its intended strength being a multi-disciplinary model comprising of several government and non - governmental partners providing the necessary services

8.2.5 The aim of the Thuthuzela Care Centre (TCC) is to provide survivors of sexual offences with immediate medical care, reduce secondary trauma for the survivor, improve perpetrator conviction rates and reduce turnaround time for finalising cases

8.2.6 The Thuthuzela Centre model aims to work in such a manner that survivors of sexual offences in its various forms can receive specialised care from police officers who record their statements, collect exhibits, and follow up on initial investigation leads.

8.2.7 Cases reported through TCCs have been linked with higher conviction rates, but only 44 of 55 TCCs nationwide were fully operational in 2014/15.[67] TCCs are also overwhelmingly donor-funded, as opposed to state-funded, which results in inconsistent funding flows to the TCCs. An example of this is a recent decision by a major donor in this regard has led to a withdrawal of funds from 27 TCCs. In June 2019, it was reported[68] that half of TCCs across the country were without counselling services or relied on only one or two social workers to assist victims of sexual abuse and violence, due to lack of funding. This directly impacts the psycho-social support and counselling services offered to victims. The South African government has not moved to close this funding gap, despite promoting the model as best practice globally.

[67] Pg 73 of the National Prosecuting Authority Annual Report 2014/15, available at https://www.npa.gov.za/sites/default/files/annual-reports/Annual%20Report%202014%20-%202015.pdf

[68] https://genderjustice.org.za/news-item/sonke-is-alarmed-by-funding-crisis-faced-by-thuthuzela-care-centres-and-the-impact-on-survivors-of-gender-based-violence/

8.2.8 It is important to stress that the model can work well if there is full and complete commitment and participation by all stakeholders, including the SAPS. Unfortunately, to date, this is largely not the case.

8.2.9 The model also relies on the participation, integration of civil society organisations and services who provide a range of services including counselling, legal advice, court support, practical support. These NGO services are chronically underfunded by the state.

8.2.10 The current operation and roll-out of TCC's nationally require the continued commitment and involvement of SAPS, including the allocation of adequate resources.

8.3 Victim Empowerment Services in SAPS:

8.3.1 The South African Police Service's (SAPS) National Instruction 22/1998 provides clear instructions to the SAPS on how to support victims.[69] A key deliverable in this regard is victim-friendly rooms in which to interview victims of both domestic and sexual violence. SAPS have claimed that all police stations in South Africa offer "victim-friendly services".[70]

8.3.2 SAPS describes victim-friendly service as a service that protects the dignity and rights of victims, empowers victims, and ensures that they are not subjected to secondary victimization by inefficient members of the criminal justice system.

8.3.3 The four elements of victim empowerment are listed as: emotional and practical support, providing information, and referral to professional support services.

8.3.4 However, the lived experience of victims and Shukumisa research findings[71] clearly indicate that these rooms and services are not consistently available or utilized for their intended purposes.

9. All these specialised services and response mechanisms would function effectively if they were adequately capacitated and financially provided. This has limited the impact of these specialised services for survivors of violence against women.

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[69] Sigsworth, Vetten, Jewkes & Christofides *Tracking Rape Case Attrition in Gauteng: The Police Investigation Stage* (2009)
[70] South African Police Service presentation to the parliamentary Portfolio Committee on Police, on 18 August 2015, available at https://pmg.org.za/committee-meeting/21337/
[71] Shukumisa monitoring reports 2009 – 2014, available at http://www.shukumisa.org.za/resource-archive-list/