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SOCIAL AND CULTURAL RIGHTS

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AMNESTY
INTERNATIONAL



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1. INTRODUCTION

Amnesty International submits this briefing to the United Nations (UN) Committee on Economic, Social and Cultural Rights (“the Committee”) in advance of its examination of South Africa’s initial report on the implementation of the International Covenant on Economic, Social and Cultural Rights (ICESCR) in October 2018.

Amnesty International welcomes South Africa’s ratification of the Covenant in January 2015. In this briefing Amnesty International provides information based on the organisation’s research findings relating to South Africa’s implementation of the Covenant. It focuses on two areas: the right to adequate housing and the right to health in relation to Articles 11 and 12 of the Covenant. This submission also acknowledges the progress that has been made in improving access to social, economic and cultural rights in South Africa since 1994. However, persistent inequalities remain and this is not an exhaustive account of the organization’s concerns.

2. RIGHT TO ADEQUATE HOUSING (ARTICLE 12)

South Africa’s Constitution provides that “everyone has the right to have access to adequate housing”.¹ However, the country’s history of colonial and apartheid repression and continuing inequality is manifested in spatial inequity and a severe shortage of housing. With a back-log of housing estimated in 2016 at over 2.1-million,² the challenge is exacerbated by rapid urbanisation and high rates of unemployment and poverty.³ Despite an increase in the provision of housing and related essential services since 1994, over 13 percent of people in South Africa live in informal settlements.⁴ The Department of Human Settlements acknowledge that “there are over 1.8 million dwellings which can be classified as inadequate housing” and that the failure to meet housing targets rests, in part, with the failure of provinces and municipalities to spend their budget allocations.⁵ The Department also note that “the number of households living in shacks, in informal settlements and backyards increased from 1.45 million in 1996 to 1.84 million in 2001, an increase of 26%, which is far greater than the 11% increase in population over the same period”.⁶

¹ Constitution of the Republic of South Africa, Act 108 of 1996, Section 26 (1).

² Engineering News, 22nd April 2016 *Housing backlog at 2.1m, says Minister Sisulu* <http://www.engineeringnews.co.za/article/housing-backlog-at-21m-says-minister-sisulu-2016-04-22>

³ Statistics South Africa, 2017, *Poverty Trends in South Africa: An examination of absolute poverty between 2006 and 2015*.

⁴ Statistics South Africa, GHS Series Volume VII: Housing from a human settlement perspective, In-depth analysis of General Household Survey (2002-2014) and Census (1996-2011) data, April 2016. <http://www.statssa.gov.za/?p=6429>

⁵ HUMAN SETTLEMENTS 2018/19 BUDGET VOTE BY THE MINISTER OF HUMAN SETTLEMENTS, NOMAINDIYA MFEKETO, MP, AT THE NCOP, 7 JUNE 2018.

<http://www.dhs.gov.za/sites/default/files/speeches/Minister%27s%20NCOP%20Budget%2007%20June%2018.pdf>

⁶ National Department of Human Settlements, *Breaking New Ground, A COMPREHENSIVE PLAN FOR THE DEVELOPMENT OF INTEGRATED SUSTAINABLE HUMAN SETTLEMENTS, 2004* http://www.dhs.gov.za/sites/default/files/documents/26082014_BNG2004.pdf

The South African Human Rights Commission has found that many of those living in poverty in South Africa continue to live in “deplorable conditions without access to basic services or the economic opportunities required to escape from poverty.”⁷

In 2016, Amnesty International reported on the violations of the right to housing for mining-affected communities.⁸ In its *Smoke and Mirrors* report, the organisation focused on the highly inadequate housing situation and squalid living conditions for mine workers in Nkaneng, one of the main informal settlements in Marikana. Many miners in Marikana are migrant workers coming from other provinces of South Africa or from neighbouring countries. In the national context, Statistics South Africa have highlighted that migrant workers remain more likely to live in informal settlements than non –migrant households, and are amongst the most vulnerable economic marginalization.⁹

Conditions in the Nkaneng settlement, adjacent to the Marikana mine are bleak. With an expanding population of over 15,000, it comprises thousands of shacks constructed mainly from metal sheets and bits of wood. These structures are crowded together, surrounded by litter and, when it rains, by mud. They have doors but few have proper windows. In winter the shacks are cold, and during heavy rains, they can leak and suffer damage. Shacks generally comprise one or two rooms, and many people cook, sleep and bath in a single room. Access to water is limited and people living at Nkaneng report having to buy water daily. The sanitation consists of pit latrines, often shared by many households and frequently in poor condition. Sometimes when it rains they flood and are unusable. The smell from the latrines in the crowded settlement causes serious discomfort to the people living there. An assessment done by the mining company Lonmin found that 84% of households in the Greater Lonmin Community, which includes the Nkaneng informal settlement, do not have safe, environmentally friendly, decent sanitation facilities.¹⁰

At Nkaneng sanitation is mainly comprised of pit latrines, some built by the municipality. The latrines are often shared by several households. Residents told Amnesty International they face delays waiting for the municipality to dig latrines and that, once dug, they can be full and smelling in a matter of days. The smell from overused latrines is a serious complaint amongst residents. During heavy rain, the latrines can flood and become unusable.

On 16 August 2012, 34 mineworkers were killed by the South African Police Services (SAPS), following a protracted strike and protest action over wages at Lonmin’s mine in Marikana.¹¹ The Government established the Marikana Commission of Inquiry, led by Judge Ian Farlam to “investigate matters of public, national and international concern arising out of the tragic incidents at the Lonmin Mine in Marikana”¹². The Commission found that Lonmin had failed to adhere to the terms of its Social and Labour Plan,¹³ as set out in the Mineral and Petroleum Resources Development Act, with regard to housing, and that the company had “created an environment conducive to the creation of tension and labour unrest” by not addressing the housing situation at Marikana.¹⁴

In the *Smoke and Mirrors* report, Amnesty International documented the failure of mining company Lonmin to address housing conditions at Marikana as an underlying factor for the tragic events of August 2012. Under its 2006 Social and Labour Plan, Lonmin had committed to construct 5,500 houses for workers by

⁷ <http://www.sahrc.org.za/construction-site/home/21/files/Access%20to%20Housing%202015.pdf>

⁸ Amnesty International, South Africa: *Smoke and Mirrors: Lonmin’s failure to address housing conditions at Marikana* (AFR 53/4552/2016).

⁹ Noting “migrant households are more likely to live in informal settlements than non –migrant households” Statistics South Africa, GHS Series Volume VII: Housing from a human settlement perspective, In-depth analysis of General Household Survey (2002-2014) and Census (1996-2011) data, April 2016. <http://www.statssa.gov.za/?p=6429>

¹⁰ Lonmin, Social and Labour Plan October 2013 to September 2018, page 117.

¹¹ Amnesty International, South Africa: *Smoke and Mirrors: Lonmin’s failure to address housing conditions at Marikana* (AFR 53/4552/2016), 15 August 2016: <https://www.amnesty.org/en/documents/afr53/4552/2016/en/>. Following the events at Marikana, President Jacob Zuma appointed a Commission of Inquiry known as the Farlam Commission. The Commission found that the “decisive cause” of events on 16 August was an unlawful and reckless decision taken by senior police officials on 16 August to disarm and disperse the strikers, forcibly if necessary, by the end of the next day.

¹² <http://www.justice.gov.za/comm-mrk/index.html>

¹³ Social and Labour Plans are legally binding documents based on South Africa’s Mineral and Petroleum Resources Development Act (MPRDA) and the Broad-Based Socio-Economic Empowerment Charter for the South African Mining and Minerals Industry (known as the Mining Charter).

¹⁴ Marikana Commission of Inquiry: Report on Matters of Public, National and International Concern arising out of the Tragic Incidents at the Lonmin Mine in Marikana in the North West Province, available at: <http://www.sahrc.org.za/home/21/files/marikana-report-1.pdf> p. 557

2011. By 2012 it had built just three (show houses for the purpose of allowing employees to see which type of layout they liked best and would want to buy).¹⁵

Amnesty International believes that Lonmin is not solely responsible for the appalling housing and living conditions for its mineworkers, but that the South African government is equally responsible; these failures would not have happened if the government enforced the legal provisions¹⁶ it has put in place to protect the right to adequate housing of mine workers and to address the historical discrimination and disadvantage in the mining industry.¹⁷

A shortage of housing and the need to live close to the mine has led many to live in informal settlements such as Nkaneng, within Lonmin's mine lease area.¹⁸ In a letter to Amnesty International of August 2016, Lonmin acknowledged that approximately 13,500 of its 20,000 permanent employees were "in need of formal accommodation".¹⁹ Amnesty considers that the living conditions for many Lonmin employees at Marikana are, as acknowledged by the company itself, "truly appalling",²⁰ and have been so for several years. As noted above, the housing at Nkaneng, built from tin sheets and scrap materials, falls abysmally short of even the most basic requirements for adequacy of housing.²¹

Lonmin has maintained that its operations are consistent with its responsibility to respect human rights under the UN Guiding Principles on Business and Human Rights.²² However, Amnesty considers that Lonmin's operations are fundamentally inconsistent with respect for the right to an adequate standard of living, including adequate housing, as outlined in Article 11 of the ICESCR.²³

2.1 RECOMMENDATIONS

Amnesty International recommends that South Africa should:

- Ensure that mining companies including Lonmin fulfil their obligations under the Mineral and Petroleum Resources Development Act 2009 and related regulations²⁴ as set out in the Housing and Living Condition Standards for the South African Mining Industry 2009, to ensure "a decent standard of housing for mine workers"²⁵;
- Review the human and financial resources available to the Department of Mineral Resources to monitor and enforce mining corporations' Social Labour Plans and increase these resources to enable effective monitoring of SLPs;
- Require, that reports of mining companies to the Department of Mineral Resources on progress made to fulfil their socio-economic commitments as expressed in the Social and Labour Plan are publicly disclosed and made available and accessible to employees, local communities and other stakeholders.

¹⁵ Amnesty International, South Africa: Smoke and Mirrors: Lonmin's failure to address housing conditions at Marikana (AFR 53/4552/2016), 15 August 2016: <https://www.amnesty.org/en/documents/afr53/4552/2016/en/>

¹⁶ These legal provisions refer to the Social and Labour Plans (SLPs) which are legally binding. Failure by mining companies to fulfil SLP commitments can lead to revoking the company's mining licence.

¹⁷ Ibid. page 53.

¹⁸ Ibid. page 53.

¹⁹ Detail from a letter from Lonmin to Amnesty International dated 1 August 2016 and annexed to the report, Amnesty International, South Africa: Smoke and Mirrors: Lonmin's failure to address housing conditions at Marikana (AFR 53/4552/2016).

²⁰ Marikana Commission of Enquiry Report, Chapter 24, Para 20, available at: <http://www.sahrc.org.za/home/21/files/marikana-report-1.pdf>

²¹ UN Committee on Economic, Social and Cultural Rights, General Comment 4: The Right to Adequate Housing (Art. 11 (1) of the Covenant), contained in UN Doc. E/1992/23, adopted sixth session (1991)

²² Amnesty International, South Africa: Smoke and Mirrors: Lonmin's failure to address housing conditions at Marikana AFR 53/4552/2016, p.53

²³ International Covenant on Economic, Social and Cultural Rights Article 11

²⁴ Department of Minerals and Energy, Housing and Living condition standards for the South African Mining Industry 2009, GOVERNMENT GAZETTE, 29 APRIL 2009 No.32166, developed in compliance with section 100(1) (a) of the Mineral and Petroleum Resources Development Act, 2002.

²⁵ Department of Minerals and Energy, Housing and Living condition standards for the South African Mining Industry 2009, GOVERNMENT GAZETTE, 29 APRIL 2009 No.32166 Section 2.1.

3. RIGHT TO HEALTH (ARTICLE 12)

Article 12 of the ICESCR protects the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. The Constitution of South Africa provides the right to “health care services, including reproductive health care”²⁶ and that “No one may be refused emergency medical treatment.”²⁷

Despite improvement in access to health services since 1994, there are significant inequalities between the private and public health systems in terms of infrastructure and resources.²⁸ Nearly 83% of the population relies on the public health system, yet the private health care sector employs the majority of health care professionals and spends nearly six times more per patient.²⁹

Amnesty International has raised concerns regarding divergent rates of spending³⁰ and disparities in maternal health outcomes between South Africa’s nine provinces and the 52 health districts, as reflected in the varying rates of unplanned pregnancies,³¹ teenage pregnancies,³² prevalence of HIV.³³

The government has recognized high rates of maternal mortality as one of the “major pandemics” facing South Africa.³⁴ Amnesty International’s research, in relation to access to antenatal care and safe abortion services, has documented that those in the poorest and most marginalized communities, including women, girls and people living with HIV, and sex workers, continue to experience physical, and economic barriers to accessing their right to health.³⁵

²⁶ Constitution of the Republic of South Africa, Act 108 of 1996, Section 27 (1) (a).

²⁷ Constitution of the Republic of South Africa, Act 108 of 1996, Section 27 (3).

²⁸ Stats SA, General household survey 2012 <http://www.statssa.gov.za/publications/P0318/P0318August2012.pdf> last accessed 6 August 2014.

²⁹ Department of Health, Human Resources for Health South Africa, (2011) HRH STRATEGY FOR THE HEALTH SECTOR 2012/13 - 2016/17, page 28; The National Service Delivery Agreement 2010 notes the disparity in per capita spending: “in 2009 nominal terms, the per capita spend in the public sector is estimated at R1,900 whilst in the private sector it is R11,300.” And that “in the public sector there are about 4,200 patients to a general doctor compared to 243 patients to a general doctor in the private sector,” page 6; HST, District Health Barometer 2012/13: Focus on Maternal Mortality, page 32.

³⁰ Amnesty International Struggle for Maternal Health: Barriers to Antenatal Care in South Africa AFR 53/006/2014, <https://www.amnesty.org/en/documents/afr53/006/2014/en/>

citing HST, District Health Barometer 2012/13: Focus on Maternal Mortality, page 32; HST District Health Barometer 2012 noting: “Districts in socio-economic quintile 5 (highest) appear to have the best access to contraception and quintile 1 (poorest), the worst,” page 97

³¹ Wabiri et al (2013) found nationally only 44.4% of pregnancies were planned, with the lowest rates in KwaZulu-Natal (25.5%). Further, almost 90% of pregnancies of those aged under 20 were unplanned.

³² Indicated by the birth rate for girls aged under 18 who gave birth at a health facility, the national average is 8%, “the highest proportion of 2012/13 under-18 deliveries was in the Eastern Cape (EC) (10.3%) and the lowest in Gauteng Province (4.8%).” See also HST, District Health Barometer 2012/13, page 60.

³³ HSRC, Shisana, O, Rehle, T, Simbayi LC, Zuma, K, Jooste, S, Zungu N, Labadarios, D, Onoya, D et al. South African National HIV Prevalence, Incidence and Behaviour Survey, 2012. Cape Town, HSRC Press (2014) The National Antenatal Sentinel HIV prevalence Survey, South Africa, 2013, National Department of Health. Available at: <https://www.health-e.org.za/wp-content/uploads/2016/03/Dept-Health-HIV-High-Res-7102015.pdf>

³⁴ The four pandemics include high rates of HIV infection and TB, maternal and child mortality, non-communicable diseases and injuries caused by violence, as set out in the RSA Negotiated Service Delivery Agreement (NSDA) For Outcome Two: “A Long and Healthy Life for All South Africans” 2010 (NSDA 2010); Government of South Africa, Minister for Health, Dr Aaron Motsoaledi MP, Budget Speech, July 2014.

³⁵ Amnesty International Struggle for Maternal Health: Barriers to Antenatal Care in South Africa AFR 53/006/2014, <https://www.amnesty.org/en/documents/afr53/006/2014/en/>; Amnesty International, Barriers to Safe and legal abortion in South Africa Index: AFR 53/006/2014 <http://amnesty.org.za/research/barriers-to-safe-and-legal-abortion-in-south-africa/>; Amnesty International South Africa, SUBMISSION TO THE MULTI-PARTY WOMEN’S CAUCUS ON THE SOUTH AFRICAN LAW REFORM COMMISSION REPORT ON “PROJECT 107 SEXUAL OFFENCES ADULT PROSTITUTION”, Index AFR 53/7950/2018.

3.1 ACCESS TO ANTENATAL CARE

In *Struggle for Maternal Health*, a report released in October 2014,³⁶ Amnesty International documented three discriminatory barriers to women and girls accessing timely antenatal care, which in turn can contribute to the high rates of maternal mortality in South Africa:

- **LACK OF PRIVACY AND INFORMED CONSENT**

Amnesty International found that practices at clinics, including the behavior of some healthcare workers, combined with staff shortages and inadequate infrastructure, regularly compromised the rights of women and girls to privacy and confidentiality at clinics.³⁷

The report also raised concerns that the implementation of HIV counselling and testing breached the right to informed consent.³⁸ Guidelines for HIV testing in South Africa make clear that health care workers must ensure that women and girls attending antenatal clinics give informed consent before they are tested for HIV.³⁹ However, these Guidelines are not being followed. Nearly all the women Amnesty International interviewed understood HIV testing as a compulsory part of antenatal care at their clinic and was required to access other routine antenatal services not dependent on their HIV status. The report raises concerns that breaches of the guidelines and the lack of informed consent around HIV testing have serious consequences of deterring pregnant women and girls from seeking antenatal care.

- **TRANSPORT AND COST BARRIERS TO ACCESS HEALTH SERVICES**

Accessibility is a key aspect of the right to health. All health facilities, goods and services must be physically and economically accessible to all, free from discrimination. The CESCR has clarified that means health services must be within safe physical reach for all sections of the population, especially marginalized groups.⁴⁰ Amnesty International documented that Many households cannot afford to pay for transport for women and girls to get to health facilities for their antenatal care, or when they need to give birth. Those living in rural areas (43.6% of the population) often experience the greatest adversities as a result in accessing quality health care.⁴¹ High numbers of births continue to take place outside of health facilities, which is a major factor in the country's high rates of maternal deaths.⁴²

- **LACK OF ADEQUATE INFORMATION**

The obligation to provide education and access to information concerning the main health problems in the community is a core, non-derogable obligation under ICESCR Article 12.⁴³ Amnesty International documented the failure of the authorities to ensure that information about sexual and reproductive health and rights is adequately disseminated and that all sections of the population are able to access it, including through comprehensive sexuality education that involves both women and girls, and men and boys.⁴⁴

³⁶ Amnesty International *Struggle for Maternal Health: Barriers to Antenatal Care in South Africa* AFR 53/006/2014

³⁷ The CESCR has emphasized in General Comment 14 (The right to the highest attainable standard of health (article 12), that; "All health facilities, goods and services must be... designed to respect confidentiality."³⁷ Public health facilities that make it difficult or impossible to keep information about health status and treatment confidential are potentially inconsistent with the right to health. UN Doc. E/C.12/2000/4.

³⁸ The Human Rights Committee has emphasized the persistence of stigma and discrimination against people living with HIV as a barrier to access of health services, especially for women and people in rural communities. Human Rights Committee, Concluding observations on the initial report of South Africa* 27 April 2016 CCPR/C/ZAF/CO/1

³⁹ Department of Health, HIV counselling and testing policy guidelines 2010; HIV Counselling and Testing of Pregnant Women for the PMTCT Programme, page 41.

⁴⁰ CESCR, General Comment 14, para 12.

⁴¹ Department of Health, Human Resources for Health South Africa, (2011) HRH STRATEGY FOR THE HEALTH SECTOR 2012/13 - 2016/17, page 30.

⁴² Sixth report on the Confidential Enquiries into Maternal Deaths in South Africa, 2011-2013.

⁴³ CESCR General Comment 14, para 43.

⁴⁴ Amnesty International *Struggle for Maternal Health: Barriers to Antenatal Care in South Africa* AFR 53/006/2014

3.2 ACCESS TO TERMINATION OF PREGNANCY SERVICES

Amnesty International acknowledges the progressive legal framework for access to safe abortion in South Africa as provided under the Choice on Termination of Pregnancy Act (CTOPA) (1996).⁴⁵ Abortion related deaths and injuries are estimated to have reduced by over 90% since the Act came into force. Despite this progress, illegal abortions are frequently documented in South Africa.

In a briefing, released in February 2017 Amnesty International and the Women's Health Research Unit, School of Public Health and Family Medicine at the University of Cape Town have documented, three key barriers, in policies and practice, to safe abortion services⁴⁶:

- **THE FAILURE TO REGULATE “CONSCIENTIOUS OBJECTION”**

Amnesty International found that only 7% of the country's 3 880 health facilities offered termination of pregnancy services,⁴⁷ risking violations of the government's obligations under international human rights law.⁴⁸

The unregulated refusal by health care professionals to provide abortion services is a major contributor to the shortage of health facilities providing abortion services. The CTOPA stipulates that any person who prevents or obstructs access to legal abortion services is guilty of an offence, punishable by a fine or imprisonment.⁴⁹ Therefore, in terms of the law, health care providers who are not directly involved with the abortion procedure cannot use their beliefs as a reason for not assisting a woman seeking abortion services with information and appropriate referrals. Despite the clarity of the law, however, Amnesty International has highlighted an apparent lack of understanding among many health care providers and individuals working in health care facilities of the obligations the CTOPA imposes, along with concern that the lack of clear policy guidelines for all involved in health care provision creates a vacuum for conscientious objection to be applied in an “ad hoc, unregulated and at times incorrect” manner.⁵⁰ An expert review of all maternal deaths in South Africa from 2011-2013 has recommended that: “Facility managers must ensure that all doctors and nurses are aware of their professional and ethical responsibilities when on-duty, and must hold them accountable when these responsibilities are neglected.”⁵¹

- **INEQUALITIES IN ACCESS TO SERVICES FOR WOMEN AND GIRLS FROM POOR AND MARGINALIZED COMMUNITIES**

Access barriers to abortion are greatly exacerbated by the failure to ensure abortion services are available at the primary health care level. A National Department of Health audit reported in 2013, recorded 3880 public health facilities in South Africa, including over 318 hospitals.⁵² In contrast, the National Department of Health confirmed to Amnesty International in December 2016 that only 264 health facilities are providing termination of pregnancy services.⁵³ Subsequent investigation by the Mail and Guardian newspaper indicated this may be an over-estimate by the Department.⁵⁴ Access to safe abortion (both medical and surgical) is severely hampered across the country, especially in rural areas due to large distances to health facilities and the high costs of transport to reach them.

⁴⁵ As mentioned in the state's Report, under Article 3 on Gender Equality, (paragraph 74) the Choice on Termination of Pregnancy Act (CTOPA) (1996) provides for the circumstances and conditions under which pregnancy may be terminated.

⁴⁶ Amnesty International. Barriers to Safe and Legal Abortion in South Africa. AFR53/5423/2017

⁴⁷ The Department of Health's response to the request for information from Amnesty International confirmed that 505 facilities are designed to provide termination of pregnancy services and of these, only 264 health facilities are providing first and second trimester termination of pregnancy services.

⁴⁸ Amnesty International, Briefing: Barriers to Safe and Legal Abortion in South Africa Index: AFR53/5423/2017

⁴⁹ Choice on Termination of Pregnancy Act Section 10 (1) (c).

⁵⁰ Amnesty International, Briefing: Barriers to Safe and Legal Abortion in South Africa Index: AFR53/5423/2017

⁵¹ National Committee for Confidential Enquiry into Maternal Deaths, Saving Mothers 2011-2013: Sixth report on confidential enquiries into maternal deaths in South Africa Short report (2014).

⁵² National Health Care Facilities Baseline Audit National Summary Report, February 2013, at page 11.

⁵³ Information received by Amnesty International from the National Department of Health 3 November 2016.

⁵⁴ <https://bhekisisa.org/article/2017-11-20-sizamap-find-a-safe-legal-abortion-near-you-with-this-list-of-designated-providers-1>

- **LACK OF ACCESS TO INFORMATION ON SEXUAL AND REPRODUCTIVE RIGHTS, INCLUDING HOW AND WHERE TO ACCESS LEGAL ABORTION SERVICES.**

Research from South Africa has highlighted the lack of knowledge among women and girls in relation to the legality of abortion as a major driver of unsafe abortions.⁵⁵ Lack of information can lead to unnecessary delays in women and girls accessing abortion services. Delays can result in women and girls being denied abortion services due to gestational limits under the CTOPA. South Africa has high rates of second trimester abortions, which account for over 25% of abortions performed,⁵⁶ and been linked to long delays between the date of first clinic appointment and the date of admission for an abortion and complex referral processes.⁵⁷

In the context of the country's high rates of maternal deaths, medical experts have called for the government to ensure that women and girls are aware of their right to abortion and where to access services, recommending that: "Communities must be educated about...how to access safe [termination of pregnancy]".⁵⁸ As an essential first step, Amnesty International has recommended that information on which public health facilities provide abortion services and at which gestational ages, should be available on the Department of Health website and at health facilities. However, a subsequent investigation found that neither "national and provincial health departments have not been able to say where services are provided"⁵⁹ Furthermore investigations highlighted pervasive stigma towards women and girls seeking to access abortion services.⁶⁰

3.3 CRIMINALIZATION OF SEX WORK

In May 2017, the Ministry of Justice finally published the South African Law Reform Commission (SALRC) report on 'Adult Prostitution'.⁶¹ In contrast to submissions from sex work advocacy groups, the South African Commission for Gender Equality⁶² and recommendations from human rights and public health experts,⁶³ the SALRC proposed that the buying and selling of sex remain criminalised.

In their report, the SALRC acknowledged the impact of criminalization and related discrimination on access to health services, including sexual and reproductive health services and HIV testing and treatment for sex workers in South Africa,⁶⁴ However, the SALRC concluded that violations of the right to health can be addressed independently of the legislative framework governing sex work;⁶⁵ through improved training of

⁵⁵ Jewkes R et al. Why are women still aborting outside designated facilities in metropolitan South Africa? *British Journal of Obstetrics and Gynaecology*, 2005, 112:1236–1242 which found "Lack of information on abortion rights under the Act and perceived poor quality of designated facilities were the most important barriers to access and should be addressed by policymakers and health service management."; Morroni C, Myer L, Tibazarwa K. Knowledge of the abortion legislation among South African women: a cross-sectional study. *Reproductive Health*, 2006, 3:7; Harries et al. Delays in seeking an abortion until the second trimester: a qualitative study in South Africa, *Reproductive Health* 2007, 4:7

⁵⁶ J Harries et al. *J. Biosoc. Sci* (2012) 44 197-208 at page 198, noting comparable figures with the USA and UK where 12% or less of abortions take place in the second trimester; D Constant et al. Clinical out-comes and women's experiences before and after the introduction of mifepristone into second-trimester medical abortion services in South Africa, Published: September 1, 2016 <http://dx.doi.org/10.1371/journal.pone.0161843>, noting that in the Western Cape Province of South Africa, 28% of all abortions are performed in the second trimester, which is higher than reported for the United States, United Kingdom, Nepal and the Russian Federation.

⁵⁷ Grossman et al. Surgical and medical second trimester abortion in South Africa: A cross-sectional study, *BMC Health Services Research* 2011;11:224, DOI: 10.1186/1472-6963-11-224.

⁵⁸ South Africa National Committee for Confidential Enquiry into Maternal Deaths, Saving Mothers 2011-2013: Sixth report on confidential enquiries into maternal deaths in South Africa Short report (2014).

⁵⁹ <https://bhekisisa.org/article/2017-11-20-sizamap-find-a-safe-legal-abortion-near-you-with-this-list-of-designated-providers-1>

⁶⁰ <https://bhekisisa.org/article/2017-11-17-00-stigma-endangers-women-seeking-an-abortion>

⁶¹ SOUTH AFRICAN LAW REFORM COMMISSION REPORT Project 107, SEXUAL OFFENCES ADULT PROSTITUTION DATE: June 2015 First Published 2017 ISBN: 978-0-621-42727-1 <http://www.justice.gov.za/salrc/reports/r-pr107-SXO-AdultProstitution-2017-Sum.pdf> (hereafter SALRC Report).

⁶² Commission for Gender Equality (2013). "Decriminalising sex work in South Africa" http://www.gov.za/sites/www.gov.za/files/Commission%20for%20gender%20equality%20on%20sex%20work_a.pdf

⁶³ 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; UNAIDS (2002). "Sex Work and HIV/AIDS: UNAIDS Technical Update". Available: http://data.unaids.org/publications/IRC-pub02/jc705-sexwork-tu_en.pdf; World Health Organisation Department of HIV/AIDS (2012).

"Prevention and Treatment of HIV and other sexually transmitted infections for sex workers in low and middle-income countries: Recommendations for a public health approach". Available: http://www.who.int/iris/bitstream/10665/77745/1/9789241504744_eng.pdf

⁶⁴ See for example SALRC Report paras 68, 1.122, 2.94-98.

⁶⁵ SALRC Report para 2.114.

health care workers and accountability processes within the public health system and redress via the equality courts when rights are violated.⁶⁶

In a briefing to the South African Multi-Party Women's Caucus in 2018, Amnesty International disputed the findings of the SALRC report and raised concerns regarding the SALRC report process, including the lack of consultation with sex workers.⁶⁷ Amnesty International highlighted its own research findings that criminalization of sex work increased the risk of human rights violations, including the right to health.⁶⁸ Furthermore Amnesty International's submission raises concern that the SALRC report failed to reference any substantive public health or human rights research published after 2013.⁶⁹

Criminalization of sex work has specifically been shown to directly undermine global HIV prevention efforts.⁷⁰ Evidence indicates that criminalization interferes with and undermines sex workers' right to access health services and information, in particular the prevention, testing and treatment of sexually transmitted infections (STIs) and HIV.⁷¹

Amnesty International has found that sex workers are stigmatized by many law enforcement officials', , health care providers and the media as being "spreaders" of HIV – discouraging them from seeking sexual and reproductive health information and services.⁷² Additionally, police officers in many countries, including South Africa, are reported to frequently confiscate and cite the use of condoms as evidence of sex work offences, creating a disincentive to their use and further jeopardizing the right to the highest attainable standard of health.⁷³

Amnesty International has emphasized that the SALRC report also fails to reflect the best practice reflected in the South African National Sex Worker HIV Plan 2016-2019. The Plan has been heralded by UNAIDS as an innovative and holistic intervention to improve access health services for sex workers in South Africa.⁷⁴ However, the Plan also recognizes the challenges for implementing a human rights-based approach to health in the context where sex work is criminalized and supports decriminalization of sex work.⁷⁵

Amnesty International's research has also found that criminalization of sex work acts as a major barrier to police protection and access to justice for sex workers who experience sexual violence.⁷⁶ Studies from South Africa, indicate similar abuses and barriers to justice. For example, A report documenting the Policing of Sex Work in South Africa published in 2018 by Sonke Gender Justice and the Sex Work Education and Advocacy

⁶⁶ SALRC Report paras 40 and 2.468.

⁶⁷ Amnesty International South Africa, SUBMISSION TO THE MULTI-PARTY WOMEN'S CAUCUS ON THE SOUTH AFRICAN LAW REFORM COMMISSION REPORT ON "PROJECT 107 SEXUAL OFFENCES ADULT PROSTITUTION", Index AFR 53/7950/2018

⁶⁸ Amnesty International South Africa, SUBMISSION TO THE MULTI-PARTY WOMEN'S CAUCUS ON THE SOUTH AFRICAN LAW REFORM COMMISSION REPORT ON "PROJECT 107 SEXUAL OFFENCES ADULT PROSTITUTION", Index AFR 53/7950/2018. The submission draws on the research findings developed in the lead up to Amnesty International's 2016 adoption of an institutional Policy on State Obligations to Respect, Protect and Fulfil the Human rights of Sex Workers, Amnesty International Policy on State Obligations to Respect, Protect and Fulfil the Human rights of Sex Workers POL 30/4062/2016, including Amnesty International "What I'm doing is not a crime": The human cost of criminalizing sex work in the City of Buenos Aires, Argentina (Index: AMR 13/4042/2016), www.amnesty.org/en/documents/amr13/4042/2016/en/

⁶⁹ 26 May 2016, www.amnesty.org/en/documents/pol30/4062/2016/en/ (Hereafter Amnesty International Policy on the Human rights of Sex Workers).

⁷⁰ These include – but are not limited to recommendations from the scientific medical journal the Lancet <http://www.thelancet.com/series/HIV-and-sex-workers>; Recommendations from the World Health Organization (WHO), http://www.who.int/hiv/topics/sex_work/en/; Recommendations from the Global Commission on HIV and the Law, Risks, Rights and Health, 2012; Recommendations from UNAIDS, The Gap Report, section on Sex Workers, page 6, www.unaids.org/sites/default/files/media_asset/06_Sexworkers.pdf

⁷¹ See generally Global Commission on HIV and the Law, Risks, Rights and Health, 2012; UNAIDS Guidance Note on HIV and Sex Work, Annex 3; UNAIDS, UNFPA, UNDP, Sex Work and the Law in Asia and the Pacific, 2012; UNDP, UNFPA, APNSW, SANGRAM, The Right(s) Evidence: Sex, Violence and HIV in Asia – A Multi-country Qualitative Study, 2015.

⁷² "What I'm doing is not a crime": The human cost of criminalizing sex work in the City of Buenos Aires, Argentina (Index: AMR 13/4042/2016), <https://www.amnesty.org/en/documents/amr13/4042/2016/en/>

⁷³ See for example Amnesty International's public statement calling on Greece to "stop the criminalization and stigmatization of alleged sex workers found to be HIV positive", www.amnesty.org/en/documents/EUR25/004/2012/en/

⁷⁴ See Amnesty International reports: The human cost of 'crushing' the market: Criminalization of sex work in Norway (EUR/36/4034/2016); Harmfully Isolated: Criminalizing sex work in Hong Kong (ASA 17/4032/2016); Outlawed and abused: Criminalizing sex work in Papua New Guinea (ASA 34/4030/2016). See also Open Society Foundations, Criminalizing Condoms, How policing practices put sex workers and HIV services at risk in Kenya, Namibia, Russia, South Africa, the United States and Zimbabwe, 2012; Human Rights Watch, Sex Workers at Risk: Condoms as Evidence of Prostitution in Four U.S. Cities, 2012; M.H. Wurth et al., 'Condoms as Evidence of Prostitution in the United States and the Criminalization of Sex Work', Journal of the International AIDS Society, 2013.

⁷⁵ See Press Statement of UNAIDS, UNAIDS welcomes South Africa's groundbreaking National Sex Worker HIV Plan, 11 March 2016

⁷⁶ South African National Sex Worker HIV Plan 2016-2019.

⁷⁷ Amnesty International has found that the unlawful status of sex work, as well as associated stigma and discrimination, make sex workers more vulnerable to violence from other individuals, including clients, see further Sex Workers at Risk, A Research Summary on Human Rights Abuses Against Sex Workers 2016, Index: POL 40/4061/2016.

Taskforce (SWEAT),⁷⁷ found “police reportedly perpetuate serious criminal offences against sex workers and with a high frequency. These offences include violence, torture and intimidation; rape and sexual assault; harassment; corruption and bribes; unlawful arrests and detention.”⁷⁸ The Women’s Legal Centre’s 2016 report *Police abuse of sex workers* reviewed cases of human rights violations by the police, reported by sex workers, including: “being forced to pay a bribe or perform sexual favours to be released from custody, violence and discrimination, unlawful fines and arrests, and violations of procedures and standing orders and being denied access to justice”.⁷⁹ The report also cites a 2013 study where “over 50% of sex workers in a survey of 1129 sex workers [reported] having experienced violence by police and/or clients”⁸⁰ and another from 2015, where “of 410 sex workers in Port Elizabeth, 62% had been physically abused and 38% had been raped.”⁸¹

Human rights bodies and experts are increasingly focusing on the impact of punitive regulation on sex workers’ right to health, and specifically their sexual and reproductive health.⁸² The CESCR has confirmed that criminalizing consensual adult sexual activities violates states’ obligation to respect the right to sexual and reproductive health as it amounts to a legal barrier that impedes access to sexual and reproductive health services.⁸³ Therefore, states have an immediate obligation to “repeal or eliminate laws, policies and practices that criminalize, obstruct or undermine access by individuals or a particular group to sexual and reproductive health facilities, services, goods and information.”⁸⁴ The CESCR has further called on state parties to ensure that people in the sex industry have access to the full range of sexual and reproductive health care services.⁸⁵

3.4 NATIONAL HEALTH INSURANCE

In June 2018, the government of South Africa gazetted the National Health Insurance (NHI) Bill, representing efforts to achieve Universal Health Coverage. The Bill aims to create a system of NHI and make “health care delivery more affordable and accessible for the population”⁸⁶

While welcoming measures to reduce inequalities, and improve access to the right to health, Amnesty International is concerned that poor management and the lack of accountability within the public health system, as well as the failure to address deep inequalities in access to health care, will undermine the effectiveness of these reforms.⁸⁷

Over 85% of South Africa’s population relies on the public health sector. While the government has improved the monitoring of service provision, the range and quality of services provided in the Primary Health Care (PHC) and Community Health Care (CHC) public health system needs to strengthen. The government’s own quality assessment of public clinics, found only 30% of health facilities met its ‘ideal clinic standards’.⁸⁸ In

⁷⁷ *One in three sex workers surveyed report being sexually abused by police*, by Pontsho Pilane, Mail and Guardian, 16 May 2018, <https://bhekisisa.org/article/2018-05-16-00-a-third-of-surveyed-sex-workers-report-being-raped-sexually-assaulted-by-police>

⁷⁸ Sonke Gender Justice and SWEAT “The Policing Of Sex Work In South Africa: A Research Report On The Human Rights Challenges Across Two South African Provinces” December 2017 Report compiled by Donna Evans and Dr Rebecca Walker https://serve.mg.co.za/content/documents/2018/05/15/mX7wwt1NRqqrKg1FOeTO_SWEAT-Policing-Sex-Work-SA.pdf page 7.

⁷⁹ Rangasami, J; Konstant, T; Manoek, S; *Police Abuse of Sex Workers: Data from cases reported to the Women’s Legal Centre between 2011 and 2015*; Women’s Legal Centre, 2016. Page 13.

⁸⁰ SANAC, SWEAT and Impact Consulting. (2013a). Estimating the size of the sex worker population in South Africa

⁸¹ Mac AIDS (2015) *Prevention of Mother to Child Transmission Needs of Female Sex Workers Study*. Mac AIDS Fund Research Brief, June 2015.

⁸² See for example, Committee on Economic, Social and Cultural Rights, General Comment 22 (Right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights)), UN Doc. E/C.12/GC/22, 2016, para. 32; Committee against Torture, Concluding observations: Austria, CAT/C/AUT/CO/4-5, 2010, para. 22; Human Rights Council, Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Anand Grover, UN Doc. A/HRC/14/20, 2010, paras. 46-50; Human Rights Council, Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Anand Grover, UN Doc. A/HRC/23/41, para. 76(j).

⁸³ CESCR, General Comment 22 (right to sexual and reproductive health (Article 12)), UN Doc. E/C.12/GC/22, 2016, para. 570.

⁸⁴ CESCR, General Comment 22, UN Doc. E/C.12/GC/22, 2016, para. 49(a).

⁸⁵ CESCR, General Comment 22, UN Doc. E/C.12/GC/22, 2016, para. 32.

⁸⁶ National Department of Health, Press Conference on the Release of: (i) Medical Schemes Amendment Bill; (ii) The NHI Bill, Dr Aaron Motsoaledi, Minister of Health, Thursday, 21 June 2018 <http://www.health.gov.za/index.php/component/phocadownload/category/383>

⁸⁷ Amnesty International, Annual Report 2017/2018: Entry on South Africa <https://www.amnesty.org/en/latest/research/2018/02/annual-report-201718/>

⁸⁸ [http://www.hst.org.za/publications/District%20Health%20Barometers/2%20\(Section%20A\)%20PHC%20Management.pdf](http://www.hst.org.za/publications/District%20Health%20Barometers/2%20(Section%20A)%20PHC%20Management.pdf)

contrast, the private health system offers high quality services, but it employs about 80% of specialist medical practitioners, and nearly half of the doctors in the country. Costs of private health care are increasingly prohibitive, and the Department of Health paper notes only 10 per cent of the South African population can afford private medical care rates.⁸⁹

The NHI Bill proposes changes to both the public and private health sectors. It aims to “create a single framework throughout the Republic for the public funding and public purchasing of health care services, medicines, health goods and health related products, and to eliminate as far as is reasonably possible the fragmentation of health care funding in South Africa”.⁹⁰ However, Amnesty International is concerned that the Bill fails to provide detail on how the new system will be funded.⁹¹ The Bill also requires that health system users be registered with the NHI Fund “at an accredited public or private health care establishment or facility”.⁹² Based on Amnesty International’s research that rural communities struggle to access health facilities and quality services,⁹³ the organisation is concerned that administration of the NHI system may entrench current inequalities, noting that areas facing the largest challenges of deprivation and disease continue to struggle for adequate resources.⁹⁴ Currently those living in rural areas (43.6% of the population) often experience the greatest adversities accessing quality health care. For example, they are served by only 12% of the country’s doctors and 19% of nurses.⁹⁵

Indications from 11 NHI pilot sites suggest that despite enormous financial investment in the NHI program, the implementation risks being undermined by on-going challenges including poor infrastructure and equipment, late payment of private GPs and pharmacists, and lack of specialists which have yet to be addressed.⁹⁶

Health service implementation risks being further undermined by the persistent “poor performance of many provinces in implementing national health policy”.⁹⁷ Reporting to Parliament in 2017, the Health Minister highlighted the failure of provincial health management functions as resulting in “a shortage of medical staff, medicines, equipment and other medical necessities.”⁹⁸ The chairperson of the parliamentary portfolio committee on Public Service and Administration was reported to have received death threats following her investigation into the poor performance of health facilities in the Mpumalanga province.⁹⁹

In June 2017, the South African Human Rights Commission found the KwaZulu-Natal provincial Department of Health had violated cancer patients’ right to life, health and dignity, due to the lack of oncologists and functional equipment for screening and treating cancer patients in the province.¹⁰⁰ In October 2017, a public arbitration process began to hear evidence relating to the deaths of over 118 people with mental health conditions, who died after the Gauteng Department of Health moved over 1 300 patients from the Life Healthcare Esidimeni facility to hospitals and NGOs.¹⁰¹ In a report released in February 2017, the national Health Ombudsman found the relocation has breached multiple human rights of the patients’ and their families, “including but not limited to the right to human dignity; right to life; right to freedom and security of person; right to privacy, right to protection from an environment that is not harmful to their health

⁸⁹ Ibid.

⁹⁰ GOVERNMENT GAZETTE, 21 JUNE 2018, No. 41725, National Health Insurance Bill
https://serve.mg.co.za/content/documents/2018/06/21/xCv3fURdyDMXtKfaysAg_Draft_National_Health_Insurance_Bill.pdf

⁹¹ GOVERNMENT GAZETTE, 21 JUNE 2018, No. 41725, National Health Insurance Bill Section 46.

⁹² GOVERNMENT GAZETTE, 21 JUNE 2018, No. 41725, National Health Insurance Bill Section 8 (1).

⁹³ Amnesty International Struggle for Maternal Health: Barriers to Antenatal Care in South Africa AFR 53/006/2014,
<https://www.amnesty.org/en/documents/afr53/006/2014/en/>; Amnesty International, Barriers to Safe and legal abortion in South Africa
Index: AFR 53/006/2014 <http://amnesty.org.za/research/barriers-to-safe-and-legal-abortion-in-south-africa/>

⁹⁴ [http://www.hst.org.za/publications/District%20Health%20Barometers/1%20\(Section%20A\)%20Finance.pdf](http://www.hst.org.za/publications/District%20Health%20Barometers/1%20(Section%20A)%20Finance.pdf)

⁹⁵ Department of Health, Human Resources for Health South Africa, (2011) 2012/13 - 2016/17, page 30.

⁹⁶ [http://www.hst.org.za/publications/District%20Health%20Barometers/1%20\(Section%20A\)%20Finance.pdf](http://www.hst.org.za/publications/District%20Health%20Barometers/1%20(Section%20A)%20Finance.pdf) ;

<http://www.samj.org.za/index.php/samj/article/view/11569>

⁹⁷ <https://www.health-e.org.za/2017/04/03/mp-mec-fight-good-patients/>

⁹⁸ Report of the Parliamentary Monitoring Group, Minister on Public Health Facilities Ministerial Task Team report; Health Department Quarter 1 performance, 14 September 2017.

⁹⁹ <http://www.sabc.co.za/news/a/d412bb8040991725a177a7516c5f19b7/Makhosi-Khoza-receives-death-threats--20170330> ;
<https://www.health-e.org.za/2017/04/03/mp-mec-fight-good-patients/>; The MP subsequently resigned from the ANC following charges of “bringing the party into disrepute” for her criticism of President Jacob Zuma, and her calls for him resign
<http://ewn.co.za/2017/09/21/makhosi-khoza-quits-anc>

¹⁰⁰ South African Human Rights Commission, Investigative Report, Dr Imran Keeka, DA, MPL vs Addington Hospital and 3 others, KwaZulu-Natal Complaint File ref: KZ/1516/0451 <https://www.sahrc.org.za/home/21/files/Dr-Imran-Keeka.pdf>

; <https://www.sahrc.org.za/index.php/sahrc-media/news-2/item/677-sahrc-acts-to-protect-cancer-patient-s-rights-to-adequate-healthcare>

¹⁰¹ <https://www.dailymaverick.co.za/article/2017-10-10-op-ed-we-need-answers-so-that-there-will-never-be-another-esidimeni-tragedy/#.Wez4W1uCyM8>

or well-being, right to access quality health care services, sufficient food and water and right to an administrative action that is lawful, reasonable and procedurally fair”.¹⁰² The SAHRC emphasised, “[all] of the 27 NGOs where the patients were relocated were unlicensed, under-resourced and had no capacity to take on mentally ill people.”¹⁰³

¹⁰² Office of the Health Ombud ‘The Report into the ‘Circumstances Surrounding the Deaths of Mentally Ill Patients: Gauteng Province’ - No Guns: 94+ Silent Deaths and Still Counting’ (1 February 2017).

¹⁰³ South African Human Rights Commission, Civil and Political Rights Report 2016/17, March 2017, <https://www.sahrc.org.za/home/21/files/Civil%20and%20Political%20Rights%20Report%20Final%20Version.pdf>

3.5 RECOMMENDATIONS

Amnesty International recommends that South Africa should:

- Continue the provision of free antiretroviral treatment for pregnant women living with HIV and ensure that all health care facilities are appropriately resourced and accessible; and ensure that health system procedures and health workers respect all persons' rights to privacy, confidentiality and informed consent;
- Prioritize the prevention of unwanted pregnancy through access to comprehensive sexuality education and modern contraception, including emergency contraceptives, and termination of pregnancy services, as provided under the Choice on Termination of Pregnancy Act;
- Issue clear guidelines and protocols, to all health care professionals and health facility management in relation to regulation of conscientious objection and implement related accountability mechanisms, and ensure accurate information and referrals for termination of pregnancy services are provided;
- Improve knowledge among health care workers and adolescents about sexual and reproductive health and rights, including through comprehensive sexuality education that involves both women and girls and men and boys and accessible information on where to access sexual and reproductive health services, including termination of pregnancy services;
- Urgently address the persistent lack of safe, convenient and adequate transport to health facilities, and the poor condition of roads, particularly in rural settings, including through subsidized or free transport, grants to pregnant women and girls to cover transport costs, improved road infrastructure, and improved transport options;
- Ensure that sex workers have equal access to justice, health care, and other public services, and to equal protection under the law;
- Ensure the meaningful participation of sex workers in the development of law and policies that directly affect their lives and safety;
- Repeal existing laws and refrain from introducing new laws that criminalize or penalize directly or in practice the consensual exchange of sexual services between adults for remuneration.

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SOUTH AFRICA

SUBMISSION TO THE UNITED NATIONS COMMITTEE ON ECONOMIC, SOCIAL AND CULTURAL RIGHTS

64TH SESSION, 24 SEPTEMBER - 12 OCTOBER 2018

Amnesty International submits this briefing to the United Nations (UN) Committee on Economic, Social and Cultural Rights (“the Committee”) in advance of its examination of South Africa’s initial report on the implementation of the International Covenant on Economic, Social and Cultural Rights (ICESCR) in October 2018.

In this briefing Amnesty International provides information based on the organisation’s research findings relating to South Africa’s implementation of the Covenant. It focuses on two areas: the right to adequate housing and the right to health in relation to Articles 11 and 12 of the Covenant.