Public AI Index: AFR 53/013/2008

To: Health Professional Network

From: Health and Human Rights Team

Date: 16 September 2008

UPDATE: Health Professional Action

"I am at the lowest end of all" - Rural women living with HIV face human rights abuses in South Africa

Please see report (AFR 53/001/2008), Action Circular 1 (AFR 53/002/2008), Health Professional Action (AFR 53/004/2008) and Action Circular 2 (AFR 53/011/2008).

Summary

This action updates Health Professional Action AFR 53/004/2008, which was issued on 27 March 2008. In line with phase two of the campaign, it asks participants to shift their focus from targeting South African government ministers at the national level to those at the provincial levels (known as 'Members of the Executive Council' or 'MECs'). Please write to MECs in eight[1] provinces whose responsibility covers health and transport.

The objectives of this action remain unchanged, but have an updated focus. An additional Health Professional Action will be issued towards the end of the year in order to introduce new objectives within phase two of the campaign.

Amnesty International Objectives

1 - Ensure that each health sub-district in rural areas has at least one health centre designated to provide post-exposure prophylaxis (PEP) to rape survivors along with other aspects of comprehensive care and treatment.

2 - Remove the barrier of transport costs for access to health services for women living with HIV and AIDS in rural areas.

[1] We have omitted Gauteng Province because it is predominantly urban or peri-urban and because it is already the target of lobbying by a range of national NGOs.

Update for Objective 1: South African government departments have issued new regulations under the Criminal Law Amendment Act 2007

New regulations under the Criminal Law (Sexual Offences and Related Matters) Amendment Act, 2007 were issued on 22 May 2008 with many positive elements.

The new regulations cover the different parts of the new act, including the provisions relating to the services which must be provided to survivors of sexual violence. The regulations specify the legal obligations of health professionals and police officials in regard to these services. Part 1, Section 2 of the regulations states, among other things, that the police official with whom a charge is laid or the medical practitioner or nurse to whom an incident is reported, must inform the survivor or an "interested person"[2] – both verbally and in writing – of, inter alia:

- the importance of obtaining post-exposure prophylaxis (PEP) medication to prevent possible HIV infection without delay, but in any event within 72 hours after the alleged sexual assault;
- that PEP will be administered at State expense;
- that the survivor will receive free medical advice prior to the administering of PEP;
- the need to obtain medical advice and assistance regarding the possibility of other sexually transmitted infections.

Police or health care providers must provide to the survivor a list containing the names, addresses and contact particulars of "accessible" health facilities. These health facilities also have to be "designated" for the specific purpose of providing the post-sexual assault services. Under the regulations, the list of facilities may be limited to those "within reasonable distance" from the police station where the charge is laid or from the clinic or hospital where the incident was first reported. The Regulations state that if the "victim or interested person" is not able to read the information provided, its contents must be explained to her or him by the police official, medical practitioner or nurse.

One of the controversies discussed at the time of the final passing of the act concerned the requirement that the survivor had to first report the incident to the police before being able to obtain access to specialist health services. The final act and the regulations confirm that the survivor has a right to access to health services before making a criminal complaint to the police. For instance, regulation 2 (3) states that health care providers must "inform the victim… to lay a charge without delay", but after having provided the necessary health services. Amnesty International has, however, received information on cases where health care providers tell the survivor that they must report the incident to the police before they can have access to health services. This is clearly contrary to the regulations and may place the health of survivors at risk if they are too frightened or do not wish to report the incident to the police. Members of the national Department of Health told Amnesty International representatives on 8 July 2008 that these abuses have occurred, and they hoped that the new act and regulations would end this practice. They acknowledged that they still have to issue specific directives on the obligations under the new act to all public health sector staff. They also acknowledged that health facilities are often the first point of contact for victims of sexual violence.

Campaigning is now requested to encourage provincial-level departments responsible for health to fully implement plans to ensure that advancements at the policy level are translated into improved local services for survivors of sexual violence.

Update for Objective 2: The Department of Transport has issued a Rural Transport Strategy

The Department of Transport published a Rural Transport Strategy for South Africa in May 2008. The strategy document included a number of positive features including an audit of transport needs in rural areas. The strategy recognized that women living in rural village communities do face particular problems in having access to any form of transport. It also recognized in general the role of transport in poverty alleviation programmes as critical in improving access and mobility to basic essential services (including health services)

[2] An "interested person" is defined as any person who has a material interest in the well-being of a survivor, such as a spouse or life partner, parent or guardian, teacher, health service provider, the survivor's social worker, or others.

for people in remote and resource-poor areas. For instance, transportation of patients is critical to reaching health service centres in time to save lives and to improving the distribution of food parcels to patients and families in need. It recognized that an increasing proportion of resources are needed to deal with the effects of the HIV/AIDS pandemic, which it noted placed "extraordinary, increasingly unsustainable demands on local resources, social support networks and other traditional coping mechanisms." Its "general guiding principles" for rural transport systems include "inclusiveness with respect to all critical rural access needs, focusing particularly on the economic and social access needs of the rural poor and other disadvantaged groups."

Although the strategy document notes the importance of recognizing "gender differences in transport needs", this guiding principle could be strengthened by making explicit the need to develop transport plans which reflect the fact that women are disproportionately affected by poverty and experience gender-based violence. The plans should give priority to women's need for safe, reliable and affordable transport. The strategy does include a proposed project for work with sectors such as education, health and social welfare to explore the development of a voucher-based or subsidy system for users of "special needs" transport services.

Campaigning is now requested to encourage provincial-level departments responsible for transport to fully implement plans which are in conformity with the guiding principle promoting the transport needs of "the rural poor and other disadvantaged groups" and to encourage these departments to prioritise the urgent need to remove the barrier of transport costs for women living with HIV and AIDS.

Background

South Africa is continuing to experience a severe HIV epidemic in which five and a half million South Africans are HIV-infected, one of the highest numbers in the world. Fifty-five per cent of these are women.[3] At the same time South Africa has high levels of sexual and other forms of gender-based violence. In South Africa, women under 25 are three to four times more likely to be HIV-infected than men in the same age group. Women are biologically more vulnerable than men to contracting the virus through unprotected intercourse. They are also placed at risk of infection through rape, or over time when living in abusive relationships because men who are perpetrators of violence are more likely to engage in risk-taking behaviour themselves.

Despite the steady upward trend in the infection rate over the past 10 years, the South African government's response to the HIV epidemic was slow and has been characterized by conflict over policy and tense relations with civil society and the medical sector. However a recent important and positive development was the adoption in April 2007 of the new HIV & AIDS and STI Strategic Plan for South Africa, 2007-2011 (NSP). The NSP reflects a consensus between government, civil society organizations, health care providers, people living with HIV and other concerned organizations to collaborate to overcome continuing barriers to prevention, treatment and care and universal access to health services. They agreed that the challenges posed by persistent poverty as well as violence and other forms of discrimination against women had to be addressed as part of an effective overall response to the epidemic and the realization of the right to health of those affected and infected by HIV. The NSP sets out clear targets for phased implementation of its objectives from 2007 to 2011.

In addition to these developments, on 13 December 2007 the Criminal Law (Sexual Offences and Related Matters) Amendment Act (SO Act) was signed into law. Human rights, gender and legal advocacy groups had campaigned for more than 10 years for reform of the law covering the crime of rape. The 2007 Act defines rape in gender-neutral terms, applicable to all forms of "sexual penetration" (vaginal, anal and oral, by body part or an object) without consent. It defines a set of "coercive circumstances" which may indicate the presence or absence of consent. It obliges the authorities to develop a national policy framework and national instructions to ensure training and coordination in implementation of its provisions. However, the Act's protective measures and services for complainants and witnesses are more limited than originally sought by advocacy organizations. It does, however, require the public health sector to ensure that complainants have access to PEP to prevent HIV transmission as a consequence of rape.

[3] NSP (2007), pp. 22, 28.

Recommended action

Objective 1 – Please write to provincial Members of the Executive Council (MECs) for Health

- introducing yourself as a health professional concerned about human rights and briefly introduce Amnesty International;
- referring to AI's report, using its full title and publication date (18 March 2008);
- reminding the authorities that South Africa has obligations under international human rights law, regional human rights treaties and national law to protect women from all forms of violence and abuse, and to eliminate discrimination in women's realization of the right to health;
- noting the publication in May 2008 of Regulations under the Criminal Law (Sexual Offences and Related Matters) Amendment Act 2007, in particular Section 2 on provision of services for victims, and encouraging them to implement this section without delay;
- noting the concern that rural women who have been subjected to sexual violence sometimes cannot reach appropriate health care facilities due to barriers of transport costs and distances;
- calling on them to ensure that sufficient "designated centres" are established in underserved rural areas of the province as a matter of priority, to provide comprehensive health care including post-exposure prophylaxis (PEP), where clinically indicated, to rape survivors;
- calling on them to ensure that no survivor is denied access to health services on the grounds that they have not first reported the incident to the police;
- asking them to ensure that all other hospitals and clinics can provide survivors with information on the nearest designated health facility equipped to provide them with comprehensive care and treatment.

Objective 2 – Please write to provincial Members of the Executive Council (MECs) for Transport

- introducing yourself as a health professional concerned about human rights and briefly introduce Amnesty International;
- referring to AI's report, using its full title and publication date (18 March 2008);
- reminding the authorities that South Africa has obligations under international human rights law, regional human rights treaties and national law to protect women from all forms of violence and abuse, and to eliminate discrimination in women's realization of the right to health;
- noting the approval by parliament in April 2008 of the Rural Transport Strategy for South Africa, and acknowledge the recognition given in the strategy to the impact of the HIV and AIDS pandemic on local resources and social support networks;
- noting that the strategy's "general guiding principles" for rural transport systems include "inclusiveness with respect to all critical rural access needs, focusing particularly on the economic and social access needs of the rural poor and other disadvantaged groups";
- urging that special attention be given to addressing the needs of rural women, who are disproportionately affected by poverty and require regular access to hospitals and clinics living with HIV and AIDS;
- asking them to minimise barriers of cost and improve regularity of transport services, to help ensure that these women can enjoy the highest attainable standard of health.

Addresses

Objective 1

Ms L N Jajula, MEC for Health – Eastern Cape Province, Private Bag X0038, Bisho 5605, SA

Mr S T Belot, MEC for Health – Free State Province, PO Box 227, Bloemfontein 9300, SA

Ms P Nkonyeni, MEC for Health – KwaZulu-Natal Province, Private Bag X9051, Pietermaritzburg 3200, SA

Mr S C Sekoati, MEC for Health and Social Development – Limpopo Province, Private Bag X9302, Polokwane 0700, SA

Mr F Mahlalela, MEC for Health and Social Development – Mpumalanga Province, Private Bag X11285, Nelspruit 1200, SA

Ms RN Rasmeni, MEC for Health– North West Province, Private Bag 124, Rooigrond 2743, SA

Ms ES Selao, MEC for Health–Northern Cape Province, Private Bag X5049,Kimberley 8300, SA

Mr P Uys, MEC for Health – Western Cape Province, PO Box 2060, Cape Town 8000, SA

Objective 2

Mr T Mhlahlo, MEC for Safety, Security, Liaison and Transport – Eastern Cape Province, Private Bag X0023, Bisho 5605, SA

Mr S Mohai, MEC for Public Works, Roads and Transport – Free State Province, PO Box 690, Bloemfontein 9300, SA

Mr Bheki H Cele, MEC for Transport and Community Safety and Liaison – KwaZulu-Natal Province, Private Bag X9043, Pietermaritzburg 3200, SA

Mr J Piitso, MEC for Roads and Public Transport – Limpopo Province, Private Bag X9491, Polokwane 0700, SA

Mr David Mabuza, MEC for Roads and Transport – Mpumalanga Province, Private Bag X11310, Nelspruit 1200, SA

Mr F P Vilakazi, MEC for Transport, Roads and Community Safety – North West Province, Private Bag X2080, Mmabatho 2735, SA

Mr D K Molusi, MEC for Transport, Roads and Public Works – Northern Cape Province, Private Bag X5065, Kimberley 8300, SA

Mr M Fransman, MEC for Transport and Public Works – Western Cape Province, PO Box 2603, Cape Town 8000, SA

COPIES:

1) Please send a copy of at least one of your letters under either Objective 1 or Objective 2 to:

Mr Mark Heywood
Deputy Chair of South African National AIDS Council (SANAC)
C/o AIDS Law Project
PO Box 32361
Braamfontein, 2017, South Africa

Mark Heywood co-chairs the South African National AIDS Council (SANAC) with Deputy President Mlambo-Ngcuka. He is SANAC's lead civil society representative, and a high-profile, committed activist and lawyer in the area of human rights and HIV/AIDS.

2) Please send a copy of at least one of your letters under Objective 1 to:

Mr L V J Ngculu
Chairperson
Portfolio Committee on Health
Parliament of the Republic of South Africa
PO Box 15
Cape Town 8000, South Africa

OR

The Chairperson

South African Medical Association (SAMA)
PO Box 74789
Lynnwood Ridge, Pretoria 0040, South Africa

3) Please send a copy of at least one of your letters under Objective 2 to:

Mr J P Cronin
Chairperson
Portfolio Committee on Transport
Parliament of the Republic of South Africa
PO Box 15
Cape Town 8000, South Africa

OR

Ms J M Masilo
Chairperson
Select Committee on Social Services
Parliament of the Republic of South Africa
PO Box 15
Cape Town 8000, South Africa

4) Please also send copies to the diplomatic representative of South Africa accredited to your country.

If you receive no reply within six weeks of sending your letter, please send a follow-up letter seeking a response. Please send copies of any letters you receive to the International Secretariat, attention of Health and Human Rights Team, 1 Easton Street, London WC1X 0DW or e-mail: health@amnesty.org