Women's Health

Women continue to occupy a vulnerable position in society, which is reflected in their health status and in their ability to access relevant health services.

In the past few years, great strides have been made in policies to improve women's health, including the passage of the Choice on Termination of Pregnancy Act, the appointment of a National Committee for Confidential Enquiry into Maternal Deaths, and the drafting of the National Contraceptive Policy Guidelines and National Maternity Care Guidelines. However, women's health has yet to improve.

Maternal deaths continue to be unacceptably high, even taking into account the effect of HIV/AIDS on this mortality rate. Women are the majority (59%) of those infected with HIV in this country, which further undermines their health status. Women are still too often victims of violence, with estimates showing that between one in four and one in six women are in abusive relationships. The inadequacy of the health system in caring for victims of violence, as well as in offering women easy access to services such as screening services for cervical cancer and termination of pregnancy, exacerbates the plight of women in society.

This chapter looks at the health status of women in South Africa, the policies designed to improve this and the progress that has been made. It argues that women's health should no longer be seen as limited to reproductive and child health, but should be viewed more holistically, encompassing all the aspects of women's health needs throughout their lives.
Introduction

This chapter aims to assess the progress, strategies, achievements, challenges, gaps and policies that have been in place between 1994-1999 to improve women’s health. It presents a review of some of the Department of Health’s strategies that are aimed at improving women’s health. In addition it attempts to review the progress of the expansion of health services to include:

- Improving the quality of contraceptive services
- Monitoring of maternal mortality and morbidity
- Implementing services to deal with HIV/AIDS and violence against women
- Expanding cervical cancer screening services.

Women’s inferior social, economic and cultural status, their exclusion from many aspects of human development as well as their specific biological needs and functions have historically meant that women could not take good health for granted. And many women live lives characterised by poor health and inadequate access to the benefits health care can give.

Women are affected by many of the same health conditions as men, but these conditions manifest and are experienced differently. The prevalence among women of poverty and economic dependence, their experience of violence, negative attitudes towards women and girls, discrimination due to race and other forms of discrimination, and lack of influence in decision making are social realities which have an adverse impact on women’s health. Additional to the adverse effects on women themselves, women’s ill health has a broader societal impact. It impacts on children and families.

All the basic components of sexual and reproductive rights and health were articulated in the Reconstruction and Development Programme:1 mothers and children were addressed through ‘maternal and child’ health, the right of people to control their fertility was asserted, including that: ‘Every women must have the right to choose whether or not to have an early termination of pregnancy according to her own individual beliefs’; sexual health and AIDS were to be addressed through tackling sexually transmitted diseases (STDs) and through mass education; references to mental health included counselling services ‘particularly for those affected by domestic or other violence, rape or by child abuse’; ‘prevention, early detection and treatment of carcinoma of the cervix’ was included, as was the need to co-ordinate services for the youth, ‘in particular education campaigns to combat substance abuse, teenage parenthood and sexually transmitted diseases’. A commitment to empowerment and to addressing women’s health throughout the lifecycle was also made.1 Thus the basic components of sexual and reproductive health were policy in South Africa before they were articulated as international policy at the International Conference on Population and Development (ICPD) in Cairo, 1994 and the Fourth World Conference on Women (FWCW) in Beijing, 1995. The government is committed to the implementation of these international policy agreements.

In addressing women’s health issues, it is important to recognise the inter-related components and influencing factors that relate to reproductive and sexual health, particularly contraception, HIV/AIDS, adolescent fertility, cervical cancer, nutrition, termination of pregnancy (TOP), infertility, rape and violence against women.
Implementation Strategies

The South African health system has historically been fragmented, unco-ordinated and under-resourced with unequal access to the people in the country. The provision of adequate health services in rural areas has been gravely deficient. However, since 1994, maternal, child and women’s health has been recognised as a priority by the government, and the Maternal, Child and Women’s Health Directorate (MCWH) has been established as a separate directorate in the national Department of Health. The Directorate’s tasks are to facilitate the planning and reorganisation of services to address women and children’s health needs including reproductive health. In addition, the MCWH Directorate’s responsibilities include the development of standardized case management protocols for the care of women and children.

The White Paper for the Transformation of the Health System in South Africa has separate sections on ‘maternal, child and women’s health’ and on HIV/AIDS and STDS. Conceptually there is confusion regarding what constitutes reproductive health, sexual and women’s health and this filters down to provincial and district level. Most often services are understood only in terms of women’s reproduction and are linked with children’s services. Services concerning contraception, HIV/AIDS, sexual and domestic violence and cervical cancer screening should be viewed as women’s health and sexual health services.

Despite the conceptual misunderstandings, there are significant achievements, which have had a positive impact on the health of women. These include:

✦ Government’s initiative in making health care services more accessible by building more clinics and by use of mobile clinics
✦ Providing primary health care services free at the point of delivery to pregnant women and children
✦ Making maternal death a notifiable condition since 1997
✦ Appointment of a National Committee for Confidential Enquiries into maternal deaths (NCCEMD)
✦ Organising MCWH services in its own directorate with a national director
✦ Empowerment of health professionals (through in-service training) to sharpen their skills and to expand primary health care services to include antenatal care, deliveries and postnatal care
✦ Review of the Sterilisation Act, No 44 of 1998
✦ Promulgation and implementation of the Choice of Termination of Pregnancy Act, No 92 of 1996
✦ Drafting of a National Primary Health Care (PHC) package (a set of norms and standards for service delivery points)
✦ Drafting of the National Contraception Policy Guidelines
✦ Drafting of the National Maternity Care Guidelines
✦ Review and implementation of NCCEMD recommendations concerning supplies and equipment e.g. partograms, improved blood transfusion facilities, access for transport system for referrals
Strengthening of reproductive health training programmes
Redeployment of doctors to underserved areas
National Cervical Screening Guidelines

The above achievements were noted in all provinces, although some provinces have more advanced training capacity and have made more progress with the implementation of the NCCEMD recommendations.a

Most health service providers and beneficiaries indicated that the expansion of primary health care services to include maternal, child and women’s health has enabled the provision of health services to be rendered in a more comprehensive and more accessible way. Observations from the provinces and districts indicate that even though much progress has been achieved in terms of accessibility and equity, more still needs to be done.

**Contraception**

The Department of Health has been in the process of developing the ‘National Framework and Guidelines for Contraceptive Services’ since 1998 in consultation with various stakeholders. It plans to launch the new guidelines in 2001. The last official draft was completed in February 1999. The backbone of health services for women historically took the form of ‘family planning’ under the previous government’s plan of population control. The impetus for this new policy is to move away from that and to use the opportunity to increase women’s choice and access to quality women’s health services.

There is a high percentage of contraceptive use. The South African Demographic and Health Survey 19983 (SADHS) indicates that three quarters of women of reproductive age have had the experience of using contraceptive methods. Sixty two percent of South African women aged between 15 and 49 years use some form of contraception. Overall the injectable contraceptive is by far the most common method used. The total fertility rate for the 5 years preceding the SADHS was 3.3% nationally. The SADHS suggests that some groups of women are much more likely to use contraception, i.e. women in their teens and 20s, Indian and White women, those with two and three living children, urban residents and women with higher education.

Significant differences also exist in the type of method used by women of different ages, the injectable being the most popular method used by women under 40 years and female sterilisation for women over 40 years old. With regard to race, the injectable is commonly used by African and Coloured women and the pill and female sterilisation by Indian and White women.

In both urban and rural areas the onset of sexual activity ranges from around 13 to 18 years. Some 5% of men and 19% of women use contraception during their first sexual encounter. It appears that some fifty percent of all young people have had more than one sexual partner.4

Over 83% of clinics in urban areas and 78% in rural areas provided contraceptive services every working day in 1998.5 In 1999 most provinces reported that more than 95% of their clinics provided services every day of the week.5

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a Marima J, Department of Health, Subdirectorate: Women’s Health. Personal communication, June 2000.
While contraceptive services have been available for sometime, there are still many challenges to ensure quality services. Women need to be enabled to choose the kind of contraception that suits them and to have the information to make that choice. It is also apparent that in certain clinics in rural services, health systems are not in place to ensure that there is a regular supply of methods.

The main challenge however is to use the infrastructure of contraceptive services to expand other women’s health services. Women should have the opportunity to have their other needs met such as services for STDs/HIV/AIDS, cervical screening, abortion, sexual violence and antenatal care. It is evident that health workers are feeling challenged and stretched and as a result may be resistant to having to provide more services. Improved management and careful training could assist in motivating health workers.b

**Maternal mortality and morbidity**

The Confidential Enquiries system of recording and analysing maternal deaths commenced in October 1997 under the National Committee on Confidential Enquiries into Maternal Deaths (NCCEMD). The committee has produced a number of reports describing the magnitude of the problem of maternal deaths, the pattern of disease causing maternal deaths, the avoidable factors, missed opportunities and substandard care related to these deaths as well as recommending ways of decreasing maternal deaths. The information in this section is derived mostly from the Second Interim Report on Confidential Enquiries into Maternal Deaths,6 which was launched in November 2000 and includes data from 1999 up until April 2000.

Some 774 maternal deaths occurred in 1999 and were reported to the NCCEMD secretariat before 5 April 2000. This represents an increase of 98 deaths from the previous year. There was a significant increase in reported deaths from the Eastern Cape, KwaZulu-Natal and the Northern Province. The Department of Health argues that this increase is probably a reflection of improved reporting measures rather than a true increase in maternal deaths.

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b A Mabote, Department of Health. Personal communication, December 2000.
Table 1: Number of maternal deaths reported in relation to population and province in South Africa in 1998 and 1999

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Eastern Cape</td>
<td>6 302 525</td>
<td>15.5</td>
<td>56</td>
<td>8.3</td>
<td>84</td>
<td>10.8</td>
<td>1.33</td>
</tr>
<tr>
<td>Free State</td>
<td>2 633 504</td>
<td>6.5</td>
<td>94</td>
<td>13.9</td>
<td>79</td>
<td>10.2</td>
<td>3.0</td>
</tr>
<tr>
<td>Gauteng</td>
<td>7 348 423</td>
<td>18.1</td>
<td>131</td>
<td>19.4</td>
<td>123</td>
<td>15.9</td>
<td>1.67</td>
</tr>
<tr>
<td>KwaZulu-Natal</td>
<td>8 417 021</td>
<td>20.7</td>
<td>188</td>
<td>27.8</td>
<td>248</td>
<td>32.0</td>
<td>2.95</td>
</tr>
<tr>
<td>Mpumalanga</td>
<td>2 800 711</td>
<td>6.9</td>
<td>66</td>
<td>9.8</td>
<td>72</td>
<td>9.3</td>
<td>2.57</td>
</tr>
<tr>
<td>Northern Cape</td>
<td>840 321</td>
<td>2.1</td>
<td>22</td>
<td>3.3</td>
<td>18</td>
<td>2.3</td>
<td>2.14</td>
</tr>
<tr>
<td>Northern Province</td>
<td>4 929 368</td>
<td>12.1</td>
<td>27</td>
<td>3.3</td>
<td>62</td>
<td>8.0</td>
<td>1.26</td>
</tr>
<tr>
<td>North West</td>
<td>3 354 825</td>
<td>8.3</td>
<td>58</td>
<td>8.7</td>
<td>54</td>
<td>7.0</td>
<td>1.61</td>
</tr>
<tr>
<td>Western Cape</td>
<td>3 956 875</td>
<td>9.7</td>
<td>34</td>
<td>5.0</td>
<td>34</td>
<td>4.4</td>
<td>0.86</td>
</tr>
<tr>
<td>Total</td>
<td>40 583 573</td>
<td>100</td>
<td>676</td>
<td>100</td>
<td>774</td>
<td>100</td>
<td></td>
</tr>
</tbody>
</table>

Source: DoH/NCCEMD 2000: 6

The highest incidence of maternal deaths are being reported in KwaZulu-Natal with 2.95 maternal deaths per 100 000 population. The Eastern Cape reported 1.33/100 000, the North West 1.61/100 000 and the Northern Province 1.26/100 000 maternal deaths. The Department of Health believes that the above four provinces being rural should have a similar rate and argues that there is under-reporting then in the Eastern Cape, North West and Northern Province. They argue that there may be as many as 2 000 maternal deaths that are not being reported. In 1999 there were only 16 maternal deaths reported within the private sector; the NCCEMD also believe that there is under-reporting in the private sector because care is not integrated and women who die are usually managed by a physician at that stage. Although the reliability and process of data collection is still a challenge, there has been considerable improvement. The Eastern Cape still remains an area of concern in the collation of consistent and reliable data.
The five main causes of maternal deaths in 1999 were:
- Non-pregnancy related sepsis 29.6% (mainly deaths due to AIDS)
- Complications due to hypertension in pregnancy 19.0%
- Obstetric haemorrhage 15.4%
- Pregnancy related sepsis 13.9%, including septic abortions and puerperal sepsis
- Pre-existing maternal disease, 7.9% (mainly cardiac disease)

These five account for 85.8% of maternal deaths.
**Table 2: Primary obstetric causes of reported Maternal Deaths, 1998 and 1999**

<table>
<thead>
<tr>
<th>Primary cause of maternal death</th>
<th>1998 N</th>
<th>1998 %</th>
<th>1999 N</th>
<th>1999 %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct deaths</td>
<td>358</td>
<td>63.4</td>
<td>345</td>
<td>59.1</td>
</tr>
<tr>
<td>Hypertension in pregnancy</td>
<td>131</td>
<td>23.2</td>
<td>111</td>
<td>19.0</td>
</tr>
<tr>
<td>Postpartum haemorrhage</td>
<td>48</td>
<td>8.5</td>
<td>55</td>
<td>9.4</td>
</tr>
<tr>
<td>Antepartum haemorrhage</td>
<td>27</td>
<td>4.8</td>
<td>23</td>
<td>3.9</td>
</tr>
<tr>
<td>Abortion</td>
<td>32</td>
<td>5.7</td>
<td>32</td>
<td>5.5</td>
</tr>
<tr>
<td>Ectopic pregnancies</td>
<td>11</td>
<td>1.9</td>
<td>8</td>
<td>1.4</td>
</tr>
<tr>
<td>Pregnancy-related sepsis</td>
<td>41</td>
<td>7.3</td>
<td>55</td>
<td>9.4</td>
</tr>
<tr>
<td>Anaesthetic accidents</td>
<td>27</td>
<td>4.8</td>
<td>22</td>
<td>3.8</td>
</tr>
<tr>
<td>Acute collapse and embolism</td>
<td>41</td>
<td>7.3</td>
<td>39</td>
<td>6.7</td>
</tr>
<tr>
<td>Indirect deaths</td>
<td>190</td>
<td>33.6</td>
<td>219</td>
<td>37.5</td>
</tr>
<tr>
<td>Non-pregnancy-related infections</td>
<td>130</td>
<td>23.0</td>
<td>173</td>
<td>29.6</td>
</tr>
<tr>
<td>AIDS</td>
<td>82</td>
<td>14.5</td>
<td>93</td>
<td>15.9</td>
</tr>
<tr>
<td>Pre-existing maternal disease</td>
<td>59</td>
<td>10.4</td>
<td>46</td>
<td>7.9</td>
</tr>
<tr>
<td>Cardiac disease</td>
<td>28</td>
<td>5.0</td>
<td>23</td>
<td>3.9</td>
</tr>
<tr>
<td>Not classifiable</td>
<td>18</td>
<td>3.2</td>
<td>20</td>
<td>3.4</td>
</tr>
<tr>
<td>Total maternal deaths</td>
<td>565</td>
<td>100</td>
<td>584</td>
<td>100.0</td>
</tr>
<tr>
<td>Fortuitous deaths</td>
<td>20</td>
<td></td>
<td>13</td>
<td></td>
</tr>
</tbody>
</table>

**Note:** The NCCEMD note the following definitions in this regard:
- Maternal deaths: Deaths of women while pregnant or within 42 days of termination of pregnancy from any cause related to or aggravated by the pregnancy or its management, but not accidental or incidental.
- Direct: Deaths resulting from obstetric complications of the pregnancy state (pregnancy, labour and puerperium), from interventions, omissions, incorrect treatment or from a chain of events resulting from any of the above.
- Indirect: Deaths resulting from previous existing disease, or disease that developed during pregnancy and which were due to direct obstetric causes, but which were aggravated by the physiological effects of pregnancy.
- Fortuitous: Deaths from unrelated causes, which happen to occur in pregnancy the puerperium.
- Unknown: Deaths during the pregnancy or puerperium where an underlying cause was not identified.

**Source:** DoH/NCCEMD 1998:viii

There has been a reduction of direct causes of maternal deaths from 63.4% to 59.1% and an increase in indirect causes from 33.6% to 37.5%. Some 35.5% of the mothers whose deaths were reported were tested for HIV, with 68% of these being positive. In the category of non-pregnancy related sepsis, 38% were not tested for HIV, including those with pneumonia.
tuberculosis and meningitis. The NCCEMD argues that the 93 women who have died due to AIDS is an underestimate. They only classified women as having AIDS if they complied with the standard definitions of AIDS. Sixty-seven percent of women dying due to septic abortion were HIV positive, as were 46% of women dying with puerperal sepsis. These women were not classified as having AIDS because they did not fulfil the criteria.6

Even though there has been a slight decrease in the proportion of direct deaths caused by hypertension, this is not the result of improved treatment for hypertensive diseases in pregnancy. Rather it reflects the increase in non-pregnancy related sepsis, mainly AIDS-related. There is an increase in the incidence of puerperal sepsis and postpartum haemorrhage, which the Department of Health argues could be a result of HIV infection. Of the 16% of those who died of postpartum haemorrhage, 57% were HIV positive. Thrombocytopenia is a well-recognised effect of HIV infection and may have contributed to the increase in postpartum haemorrhage. Women are also dying at lower levels of care from sepsis. There is clearly an issue relating to lack of referral to a higher level of care, but also may be due in part to the masking of the signs and symptoms in women with HIV infections. Clinicians need to be more aware of the complications of HIV infections so that they can treat patients more appropriately.6

<table>
<thead>
<tr>
<th>Disease category</th>
<th>Tested %</th>
<th>Positive %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Septic abortion</td>
<td>15/26 (57%)</td>
<td>67</td>
</tr>
<tr>
<td>Puerperal sepsis</td>
<td>28/56 (51%)</td>
<td>46</td>
</tr>
<tr>
<td>Cardiac disease</td>
<td>3/23 (13%)</td>
<td>50</td>
</tr>
<tr>
<td>Post partum haemorrhage</td>
<td>7/44 (16%)</td>
<td>57</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>*0/25 -</td>
<td>-</td>
</tr>
<tr>
<td>TB</td>
<td>*0/16 -</td>
<td>-</td>
</tr>
<tr>
<td>Meningitis</td>
<td>3/5 (60%)</td>
<td>66</td>
</tr>
<tr>
<td>Malaria</td>
<td>7/21 (33%)</td>
<td>43</td>
</tr>
</tbody>
</table>

* If the patients tested positive, they were classified as having AIDS

Source: DoH/NDDEMD 2000: 16

The HIV epidemic is clearly impacting on the nature and causes of maternal deaths. While the reported deaths due to AIDS have risen from 82 in 1998 to 93 in 1999, this does not reflect the full extent of the impact of HIV on maternal mortality. An additional 41 women who if tested positive would have been classified as dying of AIDS, were not tested. There has been an increase in the number of maternal deaths which were classified as due to non-pregnancy related sepsis (130 in 1998 to 173 in 1999). Non-pregnancy related sepsis has become the major cause of maternal deaths at all levels of care. This brings into question the issue of health workers being trained and provided with protective equipment for exposure during obstetric procedures.6
CHAPTER 21

HIV/AIDS

The Department of Health has put in place a number of partnerships, plans, processes and reviews to deal with HIV/AIDS, the most recent being the HIV/AIDS and STD Strategic Plan for South Africa launched early in 2000. Despite these efforts, South Africa is facing an onslaught that is savagely affecting all sectors of society, with women bearing the brunt of the infection.

More than 59% of the 4.2 million HIV-infected persons in South Africa are women. Women of the age group 20-29 had the highest prevalence of HIV infection in 1999. Currently, an estimated 2.3 million women and 95,000 children (0-14 years) are living with HIV/AIDS in South Africa.7

Women in South Africa are especially vulnerable to the AIDS epidemic for two reasons. Firstly, the risk of becoming infected with HIV during unprotected vaginal intercourse is as much as 2-4 times higher for women than men. One major reason for this is that women have a larger surface area of mucosa (the thin lining of the vagina and cervix) exposed to their partner’s secretions during sexual intercourse. Additionally, semen infected with HIV typically contains a higher concentration of virus than a woman’s sexual secretions. Women are also more vulnerable to other STDs (multiplying the risk of contracting HIV tenfold). Younger women are even more at risk because their immature cervix and scant vaginal secretions put up less of a barrier to HIV, and they are prone to vaginal mucosal lacerations. There is also evidence that women again become more vulnerable to HIV infection after menopause. In addition, tearing and bleeding during intercourse, whether from rough sex, rape, or prior genital mutilation (female circumcision), multiply the risk of HIV infection, as does anal intercourse, which is sometimes preferred to vaginal intercourse because it is thought to preserve virginity and avoid the risk of pregnancy. Anal intercourse often tears the delicate anal tissues and provides easy access to the virus.8 Secondly, due to social inequalities it is often impossible for women to negotiate for safer sex, or even to choose their sexual partners.9

Prevention messages urging abstinence, fidelity (faithfulness to one partner), condom use, and encouraging and enabling people to get prompt treatment for STDs have the potential to help avoid HIV infection. However, for most women, their ability to make these decisions and to act upon them is crippled by their socio-economic circumstances. The majority of women in the world, including South Africa, lack economic resources, and are fearful of abandonment or violence from their male partners. Thus they have little or no control over how and when they have sex, and hence have little or no control over their risk of becoming infected with HIV.8

Health promotion messages stressing respect to women’s sexual rights are sorely lacking. In a context of endemic sexual violence against women, the Department of Health needs to disseminate affirming messages which state that the human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence. This concept of sexual rights was first articulated in paragraph 96 of the Fourth World Conference of Women in Beijing; in 1996. Government agreed to these commitments in Beijing, however, this message is only being disseminated and funded by NGOs, as in the Sexual Rights Campaign.
The specific cost, in personal and social terms, posed by the rapid spread of HIV among women is profound, given the critical roles women play in every society as food producers and processors, traders, income earners, and mothers. In the context of HIV/AIDS, women usually become infected during childbearing and productive years and are often seriously disadvantaged by their own infection and morbidity or by the morbidity and death of their partners and spouses. Women and in particular older women are having to step in to be the caregivers within their extended families in caring for their children and grandchildren who are dying of AIDS.

Women with HIV need access to health care, information and counselling and wellness management that will enable them to make informed choices – for example whether to risk breast-feeding or attempt costly bottle-feeding. At the same time, enthusiasm for saving the foetus needs to be balanced with the need to also ensure women’s access to treatment. Even if anti-retrovirals were given to prevent mother to child transmission of HIV, this would cease after the birth of the child, thus prizing the foetus’s life over the woman’s. The role of the Department of Health in combating HIV/AIDS infection has been a major issue of concern for HIV/AIDS lobby groups, political opposition parties and NGOs who believe that the government has not done enough to combat the disease.

Progress has been made in some provinces in formulating policies to integrate HIV/STD activities with primary health care (and TB in particular) and to reduce mother to child transmission, but this has taken place in a context of massive administrative restructuring, and is not uniform across the country. It is now a challenge to the Department to fully develop and implement these strategies.

**Violence against women**

As with many other issues, there are no reliable comprehensive statistics on the extent of violence against women. However as the Human Rights Report on Violence Against Women in South Africa states, ‘What is certain….is that South African women living in one of the most violent countries in the world are disproportionately likely to be victims of that violence’.10 Women do not find it easy to go through with the process of going to a police station to report this crime, thus there is always under-reporting. As a result convictions against abusers are less than adequate. With these limitations in mind, research on violence against women has estimated that between one out of every four, and one out of every six women in South Africa are in abusive relationships and that one woman is killed by her partner every six days.11 It has also been estimated that an average of 80% of rural women are victims of domestic violence.12 The South African Police Services report show that 49 289 rapes were reported in 1998.13 According to police statistics, rape was one of the few serious crimes that increased steadily by an average of 7% from 1994-1997. By comparison, the twenty most serious crimes increased by an average of 1% over the same period. When South African crime ratios are compared with those of 89 Interpol member states reflected in Interpol’s 1996 statistics, South Africa has the highest number of reported rape cases per 100 000 in the world.15

Violence against women takes many forms, such as physical, sexual, economic and psychological abuse. Traditionally, services for sexual violence were fragmented. The departments of Justice, Safety and Security and Health did not have a comprehensive plan of working together. Women who experienced sexual violence had their incident recorded under general assault and were only given services to deal with their physical ailments.
Health workers also do not believe that dealing with sexual violence is part of their work, and continue to only deal with physical ailments.\(^c\) Referral for counselling, dealing with possible STDs or the need for an abortion was not articulated in policies.

Jacobs discusses how research has shown that women who experience domestic violence are more likely to visit a health worker with health problems related to abuse than to access any other statutory service.\(^d\) In her participatory research investigating a model for the health sector to respond to gender violence, she found that health workers recognised their limitations in dealing with domestic and sexual violence and would welcome training. She also reports how doctors are notorious for failing to detect abuse and thus failing to respond to patients’ needs. At the same time it is clear that within the health system there are dysfunctional relationships between staff and patients, with staff often sharing societal norms and thus legitimising and perpetuating the problem. Services for violence against women are now part of the umbrella of women’s health services to be implemented at a primary health care level. The Vezimfihlo (an Nguni word for getting things of your chest, breaking silence) project model for a health sector response to gender violence piloted by Jacobs in two districts in the Eastern Cape and Western Cape is an excellent start to tackling this issue.

There have been a number of policy and legislative initiatives to deal with violence against women. The Domestic Violence Act was passed in 1998. The Act provides for the categories of relationships which fall under the Act to be broadened to include people living together, lesbian and gay people, young people and people living in institutions. The definition of domestic violence has been broadened to include financial abuse, emotional abuse, harassment and stalking. The general legal procedure of an interdict has been changed to a more specific protection order. It was twelve months before the Act began to be implemented.

Most efforts in implementing the Act have been initiated and funded by NGOs. These have been far reaching, from the re-orientation of magistrates to the training of police. Within the health sector, efforts have been to train nurses at primary health care level and GPs to recognise and treat sexual violence and to improve the quality of recording incidents in order to improve conviction rates.

In a study \((n = 269)\) describing the impact of service delivery regarding violence against women in metropolitan areas in South Africa, 73% of women described the emotional impact as the most debilitating.\(^15\) The 111 women who identified sexual abuse as the most serious were asked about their fears of a range of conditions. The most common single fear was that of contracting a STD (39%). This was followed by a concern about becoming pregnant (36%) and having a child (33%). Less than a third were worried about contracting HIV. Few women (14%) were worried about infertility as a result of abuse. Of the 111 who responded, 15% said they had contracted a STD and 5.5% contracted HIV. Pregnancy was reported by 14% of women who were sexually abused. Seven percent had an abortion and 6% had a child as a result of the abuse. Four percent were infertile as a result of the abuse. Clearly this data points to the need for integrated women’s health services which deal with women’s needs for counselling, STD treatment, emergency contraception and abortion services following sexual abuse.


\(^d\) Jacobs T. Border Institute of Primary Health Care. Personal communication, June and December 2000.
Medico-Legal Services

Medical evidence is central to the successful prosecution of sexual assault cases. Often, the medical evidence will be the only corroboration of the complainant’s case, required to confirm not only the fact that sexual contact or intercourse took place, and with a particular individual, but also that such a contact took place without the complainant’s consent. A thorough and well-recorded medical examination can provide circumstantial evidence to support a rape survivor’s story, by noting injuries ranging from obvious scratches and tears, to small and easily missed abrasions indicating that sexual intercourse took place without lubrication.\textsuperscript{ef}

If survivors of sexual assault are examined by health workers who are properly trained, who have experience in the field and are aware of what would assist the judiciary in reaching a decision, the chances of a conviction would be substantially improved. Examination of patients for medico-legal purpose is a specialist task; appearing in court also requires special skills. The whole experience of reporting to the police and being examined by a medico-legal practitioner can be an intimidating experience for the victim. It is, therefore, essential that those who carry out this work have specialised training.

The system of reporting assault and rape first to the police becomes more problematic for women who are afraid to contact the police or who are uncertain as to whether they wish to pursue a criminal case at the time immediately after the attack. There are potential medico-legal and jurisprudence issues that prevent hospitals from keeping a stock of ‘crime kits’ and J88 forms (the South African Police Service’s forms used for the recording of details of an alleged assault). An alternative would be for hospitals to develop protocols regarding examination for assault and rape at the time that complies with legal requirements. For instance, when a woman presents with her injuries or description of her assault or rape the standby officer at the relevant police station could be contacted to come to the health facility to register the crime report and to commence the investigation.

There are deficiencies in

i) The clinical examination and care of assault and rape victims
ii) The counselling services and
iii) The management of the evidence by health and welfare professionals in the criminal justice process.

In hospitals, medico-legal services are integrated into the general work of the institution and carried out by regular doctors working there. Nurses, although they are the main cadre of health workers servicing primary health care facilities, are not yet legally allowed to fill in J88 forms. Outside of the hospitals there are still full-time and part-time district surgeons who see patients. The integration of these services into primary health care services has meant increased access to medico-legal services to some degree for women. However, many women have reported long delays before receiving attention.

Currently NGOs and Community-Based Organisations (CBOs) are the main role players in providing counselling services to the victims of violence against women. They are also providers of victim empowerment and support. The integration of the forensic service into the general health service brings out the need to equip medical personnel with skills in counselling of women victims of violence.\textsuperscript{10, d, g}

\textsuperscript{e} Waterhouse S. Rape Crisis, Western Cape. Personal communication, August 2000.
\textsuperscript{f} Makhetha P. People Opposing Women Abuse, Gauteng. Personal communication, August 2000.
\textsuperscript{g} Usdin S. Soul City. Personal communication, August 2000.
In most health institutions, there are already people trained in HIV/AIDS counselling. It would probably be cost effective if the same people are given additional training in violence against women. Medical doctors are assumed to possess the skills to carry out a forensic examination, but this may not be true for most doctors. The Gender Unit of the national Department of Health as well as the Departments of Health in the Western Cape, Gauteng and the Eastern Cape, have taken the initiative to carry out training of medical officers and nurses in forensic examination.

The Western Cape provincial Health Department has taken steps to develop policy guidelines on the management of survivors of rape at the hospital level. These include guidelines for the management of victims of sexual assault and proper completion of the J88 examination form. Women presenting to a health institution before going to the police station will not need to be sent first to the police station. Hillbrow medico-legal clinic in Johannesburg has developed a training system for new medical officers and district surgeons. In addition, NGOs like ADAPT, Soul City, and the Women’s Health Project run training courses for health professionals.

Despite the lack of a training strategy within the public health system that will address the deficiencies in managing rape and violence against women, various NGOs have been carrying out a number training courses. CERSA-Women’s Health, Medical Research Council and the Border Institute of Primary Health in East London, for example, are in the process of piloting a training course for health professionals.

**Cervical Cancer Screening**

Screening for cervical cancer has been erratic and unevenly distributed throughout the country. The Department of Health has been developing National Guidelines for Cervical Cancer Screening in consultation with a variety of stakeholders for a number of years. These Guidelines were launched in November 2000 and most of the information in this section is from this policy. The intention of these Guidelines is to facilitate comprehensive and systematic cervical cancer screening for all South African women.

It is debatable as to whether cancer of the cervix is the most common form of cancer amongst South African women. Whilst breast cancer figures show the largest incidence of cancers in women, the National Cancer Registry argues that this could be due to fewer cervical screenings taking place. Cancer of the cervix is the most common cancer in women in developing countries. Approximately one in every 41 women will within their lifetime, develop this form of cancer. It is the most common cancer in African (31%) and Coloured (22.9%) women, and second most common in Indian (8.9%) and fourth most common in White (2.7%) women. To date no association has been found between invasive cancer of the cervix and HIV infection. Papanicolaou smears (Pap smears) to detect cervical abnormalities are the best form of secondary prevention. Cancer of the cervix is thought to be associated with a certain strain of a sexually transmitted virus, the human papillomavirus. Other related risk factors include the early onset of sexual activity, number of sexual partners, poor socio-economic conditions and parity.

The Department’s policy aims to reduce the incidence of and mortality due to cervical cancer by more than 60%. The screening programme will be introduced incrementally depending on health service capacity and the ultimate goal is to screen at least 70% of women nationally within the target age group within 10 years of implementing the programme. The proposal is for the Department to provide three smears per lifetime, with a ten-year interval between each smear, commencing after 30 years of age.
The success of screening programmes is dependent on good attendance rates by women at high risk. The best predictor of high risk is age. A smear as a diagnostic investigation is not regarded as an element of the screening programme. Women with an inadequate smear should be re-screened; if the second is also inadequate, the women should be referred to a known competent screening service. Women screened for the first time at age 55 or more will have only one smear if the first smear is normal.

The management objectives of the policy are:

✦ To reduce the incidence of carcinoma of the cervix, primarily by detecting and treating the pre-invasive stage of the disease
✦ To reduce the morbidity and mortality associated with cervical cancer; and
✦ To ultimately reduce the excessive expenditure of scarce health funds currently spent on invasive cancer of the cervix.

Provinces are now in the process of developing action plans to implement screening services. The challenge is for health services at primary health care level to expand and include cervical screening as a regular service, along with other women’s health services. Part of the challenge is to manage the process of screening, and ensure that services have the equipment needed, including specula and spatulas. Health systems need to be strengthened in order to provide for good co-ordination between laboratories and the health services and referral centres for follow up and treatment. At the same time, health workers need to be motivated and trained with regard to the policy, in order for them to identify target women to screen and to have a referral system to rely on.

Role of NGOs and CBOs in women’s health

NGOs and CBOs provide a supportive role to the government, complement the work of the public service and most importantly NGOs lobby and advocate for changes in society. Various NGOs, like ADAPT, Planned Parenthood Association of South Africa, Rape Crisis, National Network on Violence Against Women, People Opposing Women Abuse, and The Women’s Health Project have contributed towards improving women’s health by providing the following services:

✦ Information, education and communication (IEC) services
✦ Provision of contraception services and other reproductive health and rights services
✦ Lobbying and advocacy for legislative reforms and better services for women
✦ Providing counselling and support services to survivors of violence against woman and all people infected or affected by HIV/AIDS
✦ Institutional and individual capacity building through training; in e.g. sexual assault, empowerment, capacity building, reproductive health, sexual rights
✦ Mobilisation of community members
✦ Research and policy development.

Conclusions

The transformation of the health system in South Africa has resulted in many new policies and programmes. However, the pace at which these reforms are taking place is slow and the implementation of policies is not uniform throughout the country. The result is that the quality of health care services rendered to women is still compromised. For example the integration of Maternal, Child and Women’s Health services into Primary Health Care is positive in principle. However, unless extra resources are made available to assist all categories of the health team to understand the new tasks and policies, services will remain inadequate.

From a health management and systems perspective, the concept of women’s health still needs to be articulated and mainstreamed, despite all the different policies concerning women’s health. Women’s health is more than reproductive health and children’s health. As can be seen from the issues raised in this chapter, interventions and services for women’s health are much broader than reproductive health or maternal health and child care. For example, most women who seek contraception, whether adolescents or older women do not want to have children (at the time). Health workers who attend to those seeking contraception could also take the opportunity to discuss issues around negotiating safer sex, the use of condoms as preventative strategies for STDs including HIV, and cervical cancer. Women who present following an incident of sexual violence also need services for emergency contraception, counselling and to deal with the possible contraction of STDs including HIV.

The definition of comprehensive health services for women, as health care which treats and acknowledges women’s health needs holistically through their lifecycle, needs to be articulated and understood at national, provincial and district level. Conceptual clarity and more focus will encourage health services to be more directed.

Challenges and Recommendations

Data

In many of these women’s health issues, there is inadequate data. The challenge is to improve the management of information systems so that the Department can have information readily available to make decisions, review strategies, and formulate policies that will enable the delivery of women’s health care needs in a more equitable way.

Contraception

Although contraceptive services are widely available, there is still a need to expand such services so that they become readily available in all health institutions, to ensure that there is a regular supply, available at all times. There is also a need to expand female condom availability. The relationship between clients and service providers needs urgent attention to enable clients to feel that they are choosing the contraceptive that best suits them as opposed to the health provider. Health workers also need to take this opportunity to counsel clients on issues such as safer sex practices to prevent the spread of STDs including HIV.

Maternal deaths

Those maternal deaths not caused by HIV/AIDS could be prevented with good quality of care management protocols, proper referral systems, better transport and communication systems and regular in-service training courses for health professionals in maternity care.
Abortion on request should be available to women, and clinics need to ensure that their referral service is working should the clinic not be a designated facility or provide the service at a particular trimester. Women who test positive for HIV also need to be told of their right to a termination of pregnancy. Now that most maternal deaths are caused by non-pregnancy related sepsis related to HIV/AIDS, this needs careful management. Protocols for the identification and treatment of various infections and sepsis need to be developed for primary health care facilities.

**HIV/AIDS**

The importance of the need to encourage women to develop and enhance their sexual health by being able to negotiate safer sex cannot be over-emphasised. Similarly, women who present to a facility having experienced sexual violence, need to be counselled as to how to go about obtaining post-exposure prophylaxis if possible and how to deal with re-infection issues.

**Violence**

Awareness of sexual violence is very high, but despite this, violence against women will not be eliminated until something can be done to change community values, cultural attitudes and beliefs that give rise to men's abusive behaviour towards women and permit such behaviour to persist. There are efforts at reform within the justice and safety and security arenas, however our focus has to be on how the health sector should be dealing with violence against women. Efforts underway to train health workers at all levels in terms of recognising sexual violence and in providing counselling for survivors of sexual violence need to be supported. Health workers also have a role to play in assisting women to gain a protection order under the Domestic Violence Act. Similarly, procedures to assist women to gain evidence to convict perpetrators need to be simplified and made empowering for women.

**Cervical cancer**

Primary prevention of cervical cancer can take place within women’s health services in providing adolescents and women with information regarding the risk of early onset of sexual activity, multiple partners and unsafe sex. The new guidelines on cervical cancer screening aim to provide all South African women with an opportunity to be screened for cervical cancer. The challenge is to ensure that the policy is implemented and that women who are at risk are identified for screening; at the same time to use this opportunity to ensure that all health facilities have in place systems of working with laboratories, transport, referral and follow up.