The Politics of Women's Health in South Africa
Mandisa Mbali & Sethembiso Mthembu
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Introduction

There are several interrelated crises in women’s health in contemporary South Africa. Since the 1990s, HIV/AIDS has been considered foremost among these and it has posed a demographic, health, social and cultural catastrophe for South African women. HIV has become the leading cause of maternal mortality in South Africa, according to the government’s own statistics (Ramogale et al., 2007). Women’s social and health statuses are also being blighted by the high rates of intimate partner violence and sexual assault in the country. A recent global perception poll of the ‘best and worst’ group of 20 countries for women canvassed the views of 370 gender experts from five continents (Thomson Reuters Foundation, 2012b). South Africa was ranked 16th out of the group of 20 countries, right above Indonesia, Saudi Arabia and India, because it has “Some of the highest rates of sexual and gender-based violence in the world, a blight on a country where women are well represented in politics” (Thomson Reuters Foundation, 2012b). This concern has been echoed by Interpol which recently dubbed South Africa ‘the world’s rape capital’, where a woman is sexually assaulted every 17 seconds (SABC, ‘South Africa world’s rape capital: Interpol’, 19 May 2012).

In this Agenda special issue we have gathered pieces from an emerging literature on issues related to the politics of women’s health in post-Mbeki-era South Africa. In our call for papers, we indicated our desire to provide a forum to deepen and widen scholarly and activist conversations on women’s health issues in this country: we wanted to find papers which would provide fresh analyses in relation to well-documented issues such as maternal mortality and domestic violence and also bring to the fore new work on under-examined issues such as cervical cancer and coercive sterilisation, especially as these affect women living with HIV.

We think that the scholarship and activist writing we have gathered will not merely be of interest to gender specialists, but will be pertinent to all who follow development and governance in this country. The basis for our assertion is that, as this special issue indicates, South African feminist scholars and activists are highlighting both the gendered, redistributive limitations of the post-apartheid state and challenges facing the women’s advocacy organisations in our country.

The Politics of Women’s Health in South Africa: The role of the state

At the core of the rationale behind this special issue is the idea that there is a discernible ‘politics of women’s health’, which is expressed in women’s experiences of state service-delivery in relation to their sexual and reproductive health. We chose this focus for two reasons. Firstly, because South Africa is living through a serious and entrenched AIDS epidemic which disproportionately affects women. Secondly, because women in this country cannot routinely implement their sexual and reproductive decisions in a safe manner, even when they attend state health facilities.

To turn to how the papers conceptualise the politics of women’s health: when we
designed the theme, we thought about it in the feminist sense — one which holds that the private sphere of the family, the home and our intimate relationships have historically been, and still are, infused with power (Bozzoli, 1983; Fraser, 1992). Moreover, we wanted to indicate our affinity with the thinking of feminists who have argued for state intervention into this ‘private space’ to combat problems such as intimate partner violence and defend women’s rights to make autonomous sexual and reproductive choices (Vetten and Motelow, 2004; Albertyn, 2007). Conversely, it would be meaningless to talk about the politics of women’s health divorced from public contestations for control of the state, or policy making, or budgetary allocation. So, therefore, we decided to use the term politics in both senses, that is to describe how power is distributed and contested in both the public and private sphere and the implications for women’s rights and activist organising around them.

As a consequence of feminist advocacy, South Africa’s Constitution refers to sexual and reproductive rights in three places:

- The equality clause (s.9.3), which forbids discrimination on grounds of sex, gender and sexual orientation;
- Section 27. 1. A, which states that ‘Everyone has the right to have access to health care services, including reproductive health care’;
- Section 12 dealing with ‘freedom and security of the person’.

These rights in relation to sexual and reproductive health include the rights to access to information (frequently manifest in health professionals obtaining informed consent for medical procedures following adequate counselling), education, dignity, and for our bodily integrity to be respected. Everyone in South Africa has the rights to choose to engage in pleasurable safer sexual experiences free from violence and to choose whether they would like to reproduce and if so, the number of offspring they would like to have. This is also the Department of Health’s formal understanding of the concept, as outlined in its contraception policies and the Choice on Termination of Pregnancy Act, No 92 of 1996. But to fully realise women’s rights in South Africa today there is a need for the government to develop a comprehensive sexual and reproductive health policy which would address women’s health in its totality. This would enable civil servants in the Department of Health to develop detailed plans to roll-out services in line with international best practices and press the treasury to finance such interventions. It would also aid civil society in holding the government accountable in terms of whether it is taking concrete steps to improve sexual and reproductive health services in line with emerging international evidence.

As several of the papers in this special issue show, there is often a wide gap between women’s constitutional rights and their lived experiences of suboptimal health-related service delivery. This poor service delivery, which has occurred largely in the public sector, has stemmed from successive post-apartheid governments’ declining political will to improve the health system. Several of the papers highlight that women patients are frequently not being counselled correctly on their options in terms of medical tests, procedures and devices which could prevent and treat sexual and reproductive diseases and keep as wide as possible a range of reproductive choices that enhance their health and the rights at their disposal.

For instance, multiple reports have come to the fore indicating that women living with HIV have been coerced and forced to be sterilised in post-apartheid South Africa, an issue highlighted in an article by Zaynab Essack and Ann Strode. Involuntary sterilisations have adverse social and emotional impacts on women living with HIV – an already marginalised social group. Essack and Strode recommend that reproductive rights awareness-raising programmes be created for women living with HIV and that more effective mechanisms be generated to ensure that healthcare providers can be “held accountable for their human rights abuses” (Pg 30).

In their report on young women shack-dwellers’ experiences accessing sexual and reproductive health services in Durban,
Melissa O’Reilly and Laura Washington draw attention to issues of accountability for abuses at public-sector health facilities. Their focus group discussions with these poor, young women brought to light allegations that health care practitioners had subjected them to both anti-poor and sexist verbal abuse and assault.

Pranitha Maharaj’s study of perspectives and experiences of sexually active men and women in accessing contraceptive devices and drugs at public sector health facilities similarly highlights patients’ perceptions that some providers are rude and impatient, which she describes as a ‘major deterrent’ to their use. Her article states that young people are particularly concerned about the lack of privacy they experience during consultations where they are seeking contraception. In South Africa, contraception is free at public sector health facilities, so cost is not a barrier to its use. Maharaj also draws attention to numerous other health system-related barriers to wider contraceptive use, including: travel costs and patients living far away from clinics, especially in rural areas; long waiting times and health care providers failing to keep appointments. She also notes other, more psychosocial, barriers to contraceptive use such as many men and women’s fear of side-effects and many women’s wishes to abide by their partners’ desires to have more children.

There is currently a significant global debate over how to respond to a recent study which shows that injectable, hormonal contraceptives such as Depo Provera may double the risk of HIV transmission among women who use it and their partners. Depo Provera, an injectable contraceptive has been prescribed to women attending public sector health facilities since the late apartheid era. In the 1980s, critics charged that in the context of a racially segregated health system, where a limited array of contraceptive commodities were provided to patients, it was frequently provided to black women in a coercive manner. Many women still opted to take Depo Provera because they wanted a long term, reversible contraceptive method which they could readily conceal from their partners.

Further research is clearly needed on whether injectable hormonal contraceptives do, indeed, increase women’s risk of contracting HIV. Irrespective of whether the study’s findings are confirmed by subsequent research, social justice demands that South African women should be able to access a wider range of contraceptive commodities and procedures, including emergency contraception (the ‘morning after pill’) and contraceptive implants.

The gap between women’s constitutional rights and experiences of sexual and reproductive health service delivery is also highlighted by a report which is co-authored by one of us (Mthembu), and which discusses a project of Her Rights Initiative (HRI), an non-governmental organisation (NGO) which advocates for the realisation of women’s sexual and reproductive rights, with a special focus on women living with HIV. In 2011 HRI conducted workshops with women living with HIV in four provinces: KwaZulu-Natal, the Eastern Cape, the Western Cape and Gauteng. The women who participated in the workshops had not been counselled on the fact that women living with HIV have a greater likelihood of also being diagnosed with cervical cancer, the commonest form of cancer in South African women.

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end in itself and should therefore be provided as part of the continuum of cervical cancer prevention and treatment. Given the cost and infrastructural barriers to increased access to Pap smears, visual inspection with acetic acid could present a feasible approach to extending access to diagnosis of cervical cancer and its predecessors at public sector health facilities.

In addition, to reduce cases of cervical cancer one of the two HPV vaccines should be administered to all young women, including those living with HIV. At the moment, cost is the main barrier to wider access to these vaccines, which remain under patent and are currently only made available to young women attending private sector health facilities. The government, the vaccines’ manufacturers and donors, such as the Global Alliance on Vaccines and Immunizations (GAVI), should act to increase access to HPV vaccines in South Africa, especially given its high HIV-prevalence rates among young women.

This issue of women not receiving adequate counselling before and after hysterectomies is, however, far from isolated to the public sector of the health system. Nonhlanhla Mthiyane’s article in this issue deals with her small qualitative study of factors which led urban, highly educated middle-class African women to decide to undergo hysterectomies at private facilities and also their experiences of the procedure. These relatively affluent women felt disempowered because they had not received adequate information about the surgical procedure (including alternatives to it) and that they had not been “well-supported and cared for” by doctors in the post-operative period, especially in relation to the psychological impact of undergoing the procedure (Pg 83). Despite the fact that most of the women interviewed by Mthiyane had postgraduate degrees they still felt that they were in less powerful social positions than the doctors they consulted and so had to follow their advice even though they sensed that they were not psychologically ready to undergo the procedure. This demonstrates that more economically privileged women also require adequate counselling before and after hysterectomies, not least because many fear alienation of their partners’ affection owing to being infertile – a stigmatised state, given that a woman’s fertility is highly prized in many African cultures in this country.

Maternal health is an area of women’s health which excites particular concern among South African activists. South Africa’s high rate of maternal mortality is a major women’s health policy challenge. In the year 2000 world leaders committed to eight Millennium Development Goals (MDGs), which express the current international consensus on poverty. One of these is to reduce maternal mortality by three-quarters by 2015 (MDG 5). Duane Blauw and Loveday Penn-Kekana stated in the 2010 *South African Health Review* that “South Africa is definitely not on track to achieve MDG 5 and that maternal mortality has actually doubled since 1990” (2010:3). Some scholars have argued that South Africa has taken two steps back in this regard with the country’s maternal mortality ratio standing “at an astounding 400 per 100 000 live births (compared with, say, 210 for Ghana, 160 for Brazil)” (Ncayiyana 2010:689). South Africa would have to reduce that rate to 100 per 100 000 live births by 2015 to reach its MDG target.

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Some of the factors behind South Africa’s lack of progress in reducing maternal mortality were recently outlined in a Human Rights Watch (HRW) report on the phenomenon in the Eastern Cape – a report which Marion Stevens analyses in this issue. The international human rights NGO’s report on maternal health services in the province also described systematic abuse, neglect, corruption, negligence and a lack of accountability (in terms of addressing complaints) at appropriate levels. In her analysis of the HRW report, Stevens also highlights the issue of unsafe abortions – an important driver of maternal mortality, globally – and one which was not mentioned in the international NGO’s report. Stevens points to a dramatic decline in the number of abortions performed at state health facilities between 2009 and 2010, a state of affairs which was revealed in a response to a parliamentary question on the topic in March 2011. There was a 44% increase in deaths due to abortion and pregnancy-related sepsis between
2005-2007 and the Department of Health acknowledges that this ‘may’ be linked to a decline in the number of state health facilities providing termination of pregnancy services. One critical implication of Stevens’s report is that the South African experience of legalising termination of pregnancy indicates that law reforms alone cannot guarantee women’s rights to access to reproductive health services: feminists must also research and advocate on issues of policy implementation after legislation has been passed to advance women’s rights to health care services including safe abortions.

Ambitious plans are currently being drawn up by the government to overhaul the country’s health system by means of introducing a National Health Insurance (NHI) scheme. In 2011, the government released a Green Paper (draft policy proposal) on the NHI scheme. It is vital that feminist academics and civil society – including women’s organisations – offer considered responses to this proposal. This is because, as Rebecca Amollo states in her article on this topic, the NHI could “represent a milestone in the improvement of women’s wellbeing” (Pg 120). The policy could advance women’s rights in as much as they undertake most of the work of caring for sick children and relatives, which means that they have to disproportionately bear the burdens associated with the adverse consequences of an inequitable health system, with poorly functioning public sector facilities.

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But to maximize the gender-equity promoting nature of the reform, it is necessary to be attentive to the reality that men and women have different sexual and reproductive health needs which are determined by their physiological and anatomical differences. We endorse Amollo’s recommendation that specific planning and costing exercises be conducted to address the high rates of cervical and breast cancers, trauma from gender-based violence, and the sex-specific manifestations of HIV disease in women and men. We would also like to add that it would be valuable for the NHI fund to be used to adequately finance the training of life-skills teachers and health providers to build their knowledge, skills and confidence in how to adopt a human rights-based approach to providing sexual and reproductive health services. In order to ensure that women’s health needs are comprehensively addressed by the NHI scheme, adequate funds must be set aside by government to improve equipment and increase human resources and access to drugs and vaccinations. For instance, it would be valuable for the government to investigate what it would cost to change Pap smear guidelines for women with HIV in-line with international best practices and whether it represents a cost saving in terms of hysterectomies prevented and reduced hospitalisations among these patients?

We call for the Department of Health to comprehensively audit all cervical cancer treatment and prevention services provided in the public sector of South Africa’s health system, including:

- The cost and number of laboratories and laboratory staff providing Pap smears?
- The status and the efficacy of cervical cancer treatment services including among others radiotherapy, chemotherapy, and others the level of access versus the need and how much will it cost to meet the need?
- What is the level and the need for staff training in relation to cervical cancer, Pap smears, treatment of abnormal smears cervix cancer treatment and palliative care?
- How many women are provided with Pap smears, treated for abnormal smears and cervical cancer every year and at what cost?
- What sort of palliative care is provided to women living with cervical cancer and how many women access such services, and at what cost?
- The number of women who receive counselling and social support following a cervical cancer diagnosis, and at what cost?

In our view, this will facilitate proper ring-fencing of funds to prevent and treat cervical cancer within both the NHI and any other health financing mechanisms which may be created by the government in future.
Mthiyane’s article in this issue shows that at the moment, even women with medical aid who use private sector health facilities are sometimes dissatisfied with the quality of the services they have received. Her article, therefore, suggests that the redistribution of resources from the private sector to the public sector of the health system will not automatically result in women receiving the best possible health services. In addition to improving women’s access to public health services, the NHI ought to improve their quality. In this regard, like Amollo, we envisage that the proposed Office of Health Standards Compliance, which will deal with patients’ complaints and inspect and accredit health facilities, could be a channel women could use to increase the accountability of health care providers who communicate poorly with their patients and behave in otherwise unethical or unprofessional manners.

Improving maternal and child health services is both popular and necessary and it should certainly be a focus for NHI-financing. However, we would also add that women’s health interventions funded by the scheme should extend beyond those required for pregnant women to have healthy infants and include health services such as adequate cancer prevention, treatment and care, as well as provision of accessible abortion services for those with unwanted pregnancies. In our view, a woman’s health is intrinsically valuable, even if she is childless, beyond reproductive age or ill in a way which does not directly, physically harm her offspring – this is a view which we believe is aligned with the values enshrined in our country’s constitution.

Reproductive rights activism: New developments

There are some exciting green-shoots in relation to sexual and reproductive health advocacy which are outlined in some of the pieces in this issue. These new initiatives may be precursors to a revival of a national sexual and reproductive health movement. This special issue also points to developments in terms of advocacy to advance the rights of marginalised groups of women, such as widows, female sex workers and prisoners, in ways which will also protect their health.

In theory, given the country’s recent political history, women’s health in South Africa should not be in such a parlous state. As discussed above, since 1994 women have been comparatively well-represented in the country’s government. However, these laudable increases in the number of women in government have had a limited impact in terms of the economic empowerment of poor women. Hassim (2006) has noted this paradox, that women’s increasing representation in government has seldom translated into ‘substantive gender equality’ – including poor women’s economic empowerment. It is not merely an empty cliche to state that health is wealth: aside from its intrinsic importance as a human right, being in good health is critical to women’s – and men’s – labour productivity, as has been noted by economists in favour of introducing the NHI scheme (Financial Mail, ‘NHI roll-out will deliver benefits says KPMG study’, 7 November 2011).

women’s increasing representation in government has seldom translated into ‘substantive gender equality’

Post-apartheid governments in South Africa have, to date, followed a ‘gender mainstreaming’ approach to advancing women’s rights. Gender mainstreaming has not been without its feminist critics: Amanda Gouws (2005) has contended that it has substituted state-engagement with women’s lived experiences of sexist discrimination – including, for instance, in accessing health services – with technocratic, abstract readings of gender. According to Gouws (ibid), while mainstreaming entails that gender policy is everywhere in the South African state, it has become no-one’s responsibility.

In the 1990s, our country’s women’s movement successfully lobbied for two important health-related pieces of gender legislation to be passed: the Choice on Termination of Pregnancy Act, No 92 of 1996, and the Domestic Violence Act, No 116 of 1998. This advocacy was driven by two single-issue advocacy networks within the women’s movement: the National Network on Violence Against Women (NNVAW) and the Reproductive Rights Alliance (RRA) (Hassim, 2006).
As a consequence of direct feminist political lobbying at our constitutional deliberations and in our legislature, reproductive rights are interwoven into South African law – including the socio-economic rights to access to health care in our country’s constitution. In this respect, South African reproductive rights activism can be differentiated from, for instance, American ‘pro-choice’ activism which has drawn on libertarian rhetoric and rested on court-based methods (Smith, 2005; West, 2009). South African reproductive rights activism can, therefore, be understood as having moved beyond a narrow agenda promoting women having the right to ‘choose’ abortions, to a wider notion of reproductive justice: a concept which recognises that the progressive realisation of women’s (and men’s) reproductive rights in the fullest sense entails access to free contraception, abortions, child care and adequate social grants – steps which require a significant redistribution of state resources.

The Domestic Violence Act has proven deficient in terms of women’s rights to be screened by health care practitioners for domestic violence

These laws have not, however, provided a panacea in terms of the health needs of women, even in relation to termination of pregnancy – something illuminated by Stevens’s report discussed above. Aschman et al.’s article in this issue similarly highlights the ways in which the Domestic Violence Act has proven deficient in terms of women’s rights to be screened by health care practitioners for domestic violence and, if they have been victimised in this manner, to be holistically treated for all their injuries – including those which are reproductive, psychiatric, chronic and stress-related. Screening involves health care practitioners asking all female patients in all settings about whether they have been victims of violence perpetrated against them in their homes. The article calls for the Domestic Violence Act to be amended to detail which health and psycho-social services victims of these crimes are entitled to and what screening and treatment duties of health care practitioners have in relation to these patients.

This special issue also includes an article by Khathatso Mokoetle and Barbara Klugman which describes the formation of a new organisation – the Sexual Health and Rights Initiative – South Africa (SHARISA). As Klugman has written elsewhere, during the two administrations led by President Thabo Mbeki, activist demands for HIV treatment came to eclipse an emphasis on the sexual and reproductive issues which underlay the spread of the virus, at least in terms of the public’s consciousness. This was partly due to a disconnect between the social movement which called for wider access to antiretroviral therapy (the Treatment Action Campaign, or TAC) and the women’s movement (Klugman, 2011). In many ways, this change in emphasis made sense given the devastating impact of HIV – absent effective treatment – on sexual and reproductive health in the first decade of this century.

South Africa now has one of the largest antiretroviral treatment programmes in the world – a development substantially attributable to the work of the TAC and one which has facilitated a re-focusing of health activism on a wider range of sexual and reproductive health and rights issues beyond HIV/AIDS alone. We applaud contemporary efforts by sexual and reproductive health and rights activists to develop advocacy agendas and build coalitions which move beyond single-issue organising. The success of single-issue organising for HIV treatment access was built upon the development of broad coalitions which adopted tactics that opened policy-makers’ doors and forced them to change the relevant policies. It is now widely recognised by sexual and reproductive rights and health (SRHR) activists that such single issue coalitions can, however, also lead to other activist campaigns around SRHR issues being deprived of resources and media attention. SHARISA, which is emblematic of this trend, was formed following a civil society consultation process, which explored the decline of South African activism around sexual and reproductive health rights (SRHR) in the past decade. What Mokoetle and Klugman draw attention to is that while there are many different groups in civil society working on various aspects of sexual and reproductive health and rights, until very recently there was no mechanism to unite them around shared goals. The authors argue that a civil society umbrella-body such as SHARISA is necessary to hold government accountable...
in terms of policy-implementation, build a new layer of young activists in a context of the declining quality of services, and shift public opinion in favor of SRHR. It is still early days for the initiative, but it now has a director, Betsi Pendry, and some funding from the International Planned Parenthood Federation (IPPF). We are glad that SHARISA has obtained funding from such a well-known, large, international NGO but we hope that this funding will not make the fledgling coalition limit its area of focus to HIV/AIDS and family planning. Instead, we urge SHARISA to continue to pursue a comprehensive SRHR advocacy agenda. A further concern for us is whether this new network will be able to obtain the political influence that the RRA had at its height? It may be too premature to predict the future direction of such a new initiative.

Marlise Richter and Pamela Chakuvinga’s article offers a detailed account of sex worker advocates’ unsuccessful efforts to press for decriminalisation of sex work using the South African National AIDS Council (SANAC) as a platform. Their case study explores the reasons why the decriminalisation of sex work was not included as a goal in the 2012–16 National Strategic Plan for HIV/AIDS, TB and STIs. They conclude that decriminalisation was “a victim of a political trade-off between civil society and government”, “a decision to which sex workers were not party” and one which failed to address sex workers’ and their partners’ vulnerability to HIV and STI infection (Pg 64). They attribute this trade-off to SANAC’s lack of political will to advance this demand and resistance by conservative elements of government.

But decriminalisation of sex work may, eventually, come through another channel. According to very recent media reports, the ANC Women’s League has authored a discussion document on gender which makes the case for decriminalisation of sex work in preparation for the ruling party’s conference in Mangaung in December 2012. The league has argued that the current laws on sex work criminalise only the (mostly female) sellers but not their mostly male clients. They apparently want to obtain a resolution in support of decriminalising sex work and are using the advocacy around abortion legalisation as a template for how to go about this. It will be interesting to observe whether any resultant legislation for the decriminalisation of sex work which may follow the meeting at Mangaung will adhere to the Swedish model (criminalising the customer) or that of New Zealand (which almost totally removes voluntary sale and purchase of sexual acts from criminal law). We are concerned that criminalising the customer can still render sex workers vulnerable to unsafe sex and violence and that anything short of full decriminalisation, following the New Zealand model, will maintain and create barriers to sex workers gaining full access to sexual and reproductive health services.

Sex workers are far from being the only marginalised social group of women whose rights have not been substantially advanced in post-apartheid policy-making and implementation. Angela Tembo’s report on the Khuluman Support Group Widows’ Project brings to the fore the gender discrimination which many widows experience in South Africa. According to Tembo, in some traditional African cultures widows are required to undertake customs such as: mourning rituals in which they experience excessively long periods of social isolation; marriage to a male relative of their late husband; and, acceptance of dispossession of property accumulated during their marriage. These customs can have serious mental, sexual and reproductive health implications for widows, including exposing them to an increased risk of HIV infection.

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Tembo’s report is especially relevant in the light of the Traditional Courts Bill which is being considered by the National Council of the Provinces (NCOP). The Bill would make it an offense for people dwelling in rural areas not to appear before a traditional court to answer charges that they have violated African customs. It also proposes that the courts’ rulings would have the legal status of those made by magistrates. Widows already have limited recourse to justice in instances of abuse because traditional leaders and courts are frequently systematically biased against women. In particular, the courts are generally composed of male councillors who
frequently lack sympathy for women’s issues and in many areas women are not even allowed to speak or represent themselves in such courts and have to nominate male relatives to do so (Claassens and Mnisi, 2011). Annika Claassens and Sindiso Mnisi have also argued that the Bill puts at risk “the fluid and open political spaces within which significant numbers of women have managed to secure land rights during the last 15 years and threaten the return of the exclusive power to define customary law to government-appointed traditional leaders” (2001: 100–101).

Tembo adds that widows are often unaware of their rights in terms of the Promotion of Equality and Prevention of Unfair Discrimination Act (PEPUDA), No 4 of 2000. Moreover, her report offers a new and powerful line of critique against the Traditional Courts Bill: that it could undermine the health status of a group of women who are already poor and marginalised. In this sense, her report has critical implications in terms of the politics of women’s health in South Africa: she points to the need for feminist activists to work to increase public understanding of gender-related aspects of the South African Constitution and the laws based upon it. This is a critical first step towards empowering women to use relevant laws to claim rights.

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Women prisoners are extremely vulnerable to HIV infection. Miranda Young-Jahangeer profiles their participation in a popular participatory theatre project in Westville Prison in this issue. Young-Jahangeer describes this group of women as struggling with the “oppressive hegemonies” of apartheid, patriarchy, the prison hierarchy and poverty all of which have adversely affected their health (Pg 94). She discusses how her participatory theatre project has raised participants’ consciousness around HIV/AIDS. Her profile also describes one woman prisoner’s perception that the TAC’s AIDS activism has resulted in improvements in the quality of food and medicines inmates can access, including antiretroviral drug regimens.

Editors must make choices in compiling an issue of a journal, a process which is invariably shaped by the way in which they frame their call for papers and the submissions they receive. We fully acknowledge that there are several sexual and reproductive health issues affecting women in South Africa which we have not been able discuss in this issue, notably those affecting: pregnant teenagers, women who have sex with women; disabled women; female refugees, asylum-seekers and undocumented migrants; and, rape survivors. Women in this country also face critical challenges with several non-communicable diseases, especially, obesity, eating disorders, hypertension, diabetes and cancer. We hope that feminist journals will showcase policy-oriented scholarship in these areas in future.

**Conclusion**

There is a wide chasm between many women’s experiences of public sector health services which are of poor quality, inaccessible, provided in an unprofessional manner and the rights enshrined in our country’s constitution. HIV/AIDS and concomitant rises in maternal mortality are also at the centre of the crises in women’s health in South Africa. These crises are inspiring a new feminist scholarship and advocacy projects which shed light on the changing nature of the state and development policy in South Africa, as they affect women in our country.

South African women’s rights activists have successfully pressed for gender-related law reform in the past, most notably that legalising abortion. Alliances between men and women in government and civil society who were in favour of this reform were key to its success.

This suggests that whether future health-related legislation will be gender progressive may critically depend upon whether feminist health activists in civil society can forge a joint agenda with feminists in government, in the manner of the legalisation of abortion. Such strategic alliances may prove critical in the decriminalisation of sex work and the forging of an NHI which will improve women’s health.
It is unclear where promising advocacy initiatives such as SHARISA might lead, but the status quo of multiple advocate organisations lacking a common sexual and reproductive health and rights policy agenda means that they are still largely politically ineffectual. A strong civil society coalition on sexual and reproductive health and rights with a list of common demands could certainly assist in ensuring that the South African government is held accountable in terms of the progressive realisation of health services which uphold women’s dignity and rights. This is all the more important at a time when the government is fundamentally reconfiguring our health system.

Note
1. There is a whole body of feminist literature which asserts this, which we cannot comprehensively list here due to space limitations.

References

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