

Submission to the South African Human Rights Commission – Economic and Social Rights in South Africa (2006-2009)



Western Cape
Province,
South Africa

[The right to health is] an inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health, such as access to safe and portable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health.

United Nations General Comment 14 (August 2000)

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Realization of Socio-economic Rights 2006 to 2009

– review on progress on the Right to Health –

Section 1: Background



One of the most crucial challenges has been the absence of a united civil society voice to deal with the lack of progressive realisation of economic and social rights and the nurturing of a democratic society within the Western Cape.

SANGOCO Western Cape in collaboration with a **range of social formations** responded to this call for submissions as a necessary step to enable civil society and labour as social partners to engage and decisively impact on democracy to ensure meaningful participation, development and change.

This collaborative submission is made on behalf of the following partners:

SANGOCO Western Cape: The South African NGO Coalition (SANGOCO) is the largest single umbrella body of NGOs in Southern African with member organisations across the country working on a range of issues affecting South Africa's development. SANGOCO Western Cape is the provincial umbrella coalition for NGOs and CBOs located in the province.

COSATU's main broad strategic objectives have always been to improve material conditions of our members and of the working people as a whole; to organise the unorganised; to ensure worker participation in the struggle for peace and democracy

The Peoples Health Movement South Africa aims to enhance the capacity of individuals and communities to understand and take action to realize the right to health and health care in South Africa. We anticipate that a successful campaign will result in: better access to and quality of health care and health related services for people in South Africa; fewer violations of the right to health; and stronger CSO's able to lobby, advocate and organize with communities around their rights to health.

The Learning Network is a civil society network to realise the right to health which aims to engage ordinary people and civil society organisations to use human rights to advance health and access to health care. Through a process of what we refer to as participatory action research, we plan to draw experiences from the people and organisations taking part in a network to understand how best to advance access to health and health care.

Treatment Action Campaign's objectives are to campaign for equitable access to affordable treatment for all people with HIV/AIDS; campaign for and support the prevention and elimination of all new HIV infections; promote and sponsor legislation to ensure equal access to social

services for and equal treatment of all people with HIV/AIDS; challenge by means of litigation, lobbying, advocacy and all forms of legitimate social mobilisation, any barrier or obstacle, including unfair discrimination, that limits access to treatment for HIV/AIDS in the private and public sector; educate, promote and develop an understanding and commitment within all communities of developments in HIV/AIDS treatment; campaign for access to affordable and quality health care for all people in South Africa; train and develop a representative and effective leadership of people living with HIV/AIDS on the basis of equality and non-discrimination irrespective of race, gender, sexual orientation, disability, religion, sex, socio-economic status, nationality, marital status or any other ground; and campaign for an effective regional and global network comprising of organisations with similar aims and objectives.

Metro Community Health Forum: The aim of the MCHF is to ensure that there are functioning clinic health committees at every facility, in line with the NHA. The MCHFs objectives are to strengthen community participation in health. We address the health concerns of all the relevant role players that provide a health service in a specific community. Communities need to understand the services the department promises on an annual basis through their Annual Performance Plan to enable them to engage with the health authorities through the portfolio committees; to ensure that basic health services are provided to communities; to assist in negotiating service delivery where there is a lack of service.

Western Cape Disability Network: The Network aims to build a united disability movement in the province that can work at: raising awareness and understanding of the rights and needs of children and adults with disabilities of all kinds; lobbying for appropriate services for all people with disabilities; representing the rights and needs of disabled people in policy-making processes; monitoring legislation; promoting an inclusive society; and creating a genuine working partnership between service providers and disabled people themselves

Environmental Monitoring Group: We believe that society's relationship with the natural environment is inextricably bound to our relationships with each other, and that sustainable use of the planet's resources is not possible without political, economic and social justice. Our **focus** is thus on building democratic, fair and sustainable decision-making processes that relate to the use and management of natural resources. In working towards our mission, we work to: disseminate information, analysis and alternative viewpoints into the public domain, and to specific target audiences; and facilitate mutual learning, dialogue and effective action; and demonstrate and share best-practice through building partnerships, facilitating action-research and promoting dialogue.

Zanempilo Trust delivers holistic primary health care services to disadvantaged peri-urban communities in the Western Cape through community health workers (CHWs). The organisation works and networks with a range of service providers to access information and resources and to influence policies that benefit the health of the communities served. Our strategic aim is to partner and collaborate with government departments in accessing acceptable, affordable and quality services to the communities. Our strategic objectives are: to empower communities to take responsibility for their health through facilitating health promotional and educative processes at local level.

We make this submission in response to the SAHRC call for submissions to comment on progress made by the State in realizing SERs over the period 2006 to 2009 and to contribute to a better understanding of “the content of the obligation placed on the state to achieve the progressive realization of economic and social rights.” In our submission, we also attempt to make reference to progress in achieving the MDGs. The submission covers ONLY the Western Cape.

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Section 2: Outline

We have structured the submission as follows:

Section 3 presents our understanding of how to frame the right to health, both from the point of view of the delivery of health services, but also from the perspective of international human rights law and international and national policy documents. In our understanding, health, and therefore the right to health, must be understood as far broader than just health care.

For that reason, **Section 4** goes on to examine different components of the Right to Health, namely access to health care, access to safe and potable water and adequate sanitation, an adequate supply of safe food and nutrition, an adequate supply of housing, healthy occupational and environmental conditions, access to health-related education and information, including on sexual and reproductive health, and access to social security.

For each component of the right to health, we present whatever quantitative data are available that SANGOCO has been able to identify and complement quantitative data with qualitative evidence from existing research, from organizational reports and from submissions in other processes. In Section 4 we further examine in detail the thread of participation as a key element to the right to health, both within the health care system but also within state-civil society interaction in other spheres which determine the availability of services and resources needed for good health.

In **Section 5** we link the evidence presented in **Section 4** to suggestions for questions that the SAHRC might want to ask of government in its interrogation of government's submissions to this call as would be the case in a Shadow Report approach with recommendations addressed to government, civil society and to the SAHRC itself.

Finally **Section 6** provides qualitative evidence which links to the issues raised in **Section 4** and **Section 5**.

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Section 3: What is the right to health?



The International Covenant on Economic Social and Cultural Rights defines the right to health in terms of ‘the highest attainable standards of physical and mental health.’ The substantive content of what this implies is elaborated in the General Comment 14 of the UN Committee overseeing the Covenant. What is evident from the General Comments is that:

“... the right to health embraces a wide range of socio-economic factors that promote conditions in which people can lead a healthy life, and extends to the underlying determinants of health, such as food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions, and a healthy environment.”

Whereas many of the above are themselves socio-economic rights (e.g. housing, water, etc), we focus on health as the right of interest in our submission and the other factors as determinants of health, but this does illustrate the indivisibility of socio-economic rights in general.

Even though the South African government has not ratified the ICESCR, we have adopted this definition of the Right to Health in our approach to this submission and in our work as Civil Society Organisations. Since South Africa has, in fact, signed the Convention, signifying its intent to accept the provisions of the Convention, and has many provisions in its own Bill of Rights that reflect provisions already contained in the ICESCR, we think that holding South Africa to these standards is both logical and morally appropriate. Moreover, it is an appropriate international benchmark to consider progress in realizing Socio-economic rights.

This means that the right to health includes access to health care, but also extends to access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health. To this list, we would include access to education and to social security as critical to realizing the Right to Health, both being listed in the SA Bill of Rights.

As far as possible, we have tried to refer to how the evidence speaks to the way General Comment 14 sets out the ‘Normative content’ of the right to health as involving availability, accessibility, acceptability and quality (See Table 1).

The Normative Content of the Right to health

i. Availability	Meaning functioning public health and health-care facilities, goods and services, as well as programmes, in sufficient quantity; <i>Note that goods and services would include determinants requires for health such as water, sanitation, human resources, etc. Also, that availability of drugs is based on the idea of essential drugs, as defined by the WHO Action Programme on Essential Drugs).</i>
ii. Accessibility	meaning all facilities, goods and services ⁶ must be accessible to everyone
Non-discrimination	accessible to all, especially the most vulnerable or marginalized sections of the population, in law and in fact, without discrimination on any of the prohibited grounds; ⁷
Physical accessibility	within safe physical reach for all sections of the population, especially vulnerable or marginalized groups (examples cited of vulnerable groups include ethnic minorities and indigenous populations, women, children, adolescents, older persons, persons with disabilities and persons with HIV/AIDS) and rural populations
Economic accessibility	Affordability
Information accessibility	he right to seek, receive and impart information and ideas ⁸ concerning health issues (but maintaining confidentiality where appropriate)
iii. Acceptability	Ethical and culturally appropriate, respectful
iv. Quality	Scientifically and medically appropriate

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Section 4: Progress on the Right to Health

“The poor health of the poor, the social gradient in health within countries, and the marked health inequities between countries are caused by the unequal distribution of power, income, goods, and services, globally and nationally, the consequent unfairness in the immediate, visible circumstances of peoples lives – their access to health care, schools, and education, their conditions of work and leisure, their homes, communities, towns, or cities – and their chances of leading a flourishing life. This unequal distribution of health-damaging experiences is not in any sense a ‘natural’ phenomenon but is the result of a toxic combination of poor social policies and programmes, unfair economic arrangements, and bad politics. Together, the structural determinants and conditions of daily life constitute the social determinants of health and are responsible for a major part of health inequities between and within countries.”¹
(CSDH, 2008: 1)

Although this quote reflects the summation of a huge volume of evidence accumulated at international level for the WHO Commission on Social Determinants of Health, we believe this finding could be said to reflect the situation within South Africa. We present evidence below to suggest that progress on realising the right to health since 2006 has been uneven and limited by structural issues requiring serious political commitment.

Since health is the result of many social determinants, the provision of basic services is key to good health. This is evident in the fact that our Bill of Rights provides for a range of measures that are needed for health² as outlined in some of the areas below. These include:

Ensuring resources for health

The realization of the right to health, and other human rights obligations that are social determinants to health, should not be seen as a function merely of incremental budget

¹ CSDH (2008). Closing the gap in a generation: health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of Health. Geneva, World Health Organization

a) ² The right to an environment not harmful to your health: Section 24
b) The right to land: Section 25
c) The right to housing: Section 26, 28(1)(c) and 35(2)(e)
d) The right to healthcare: Section 27
e) The right to food: Section 27(1)(b), 28(1)(c) and 35(2)(e)
f) The right to water: Section 27(1)(b)
g) The right to social security: Section 27(1)(c) and section 28(1)(c) of
h) The right to basic social services: Section 28(1)(c)
i) The right to education: Section 29

allocations by the country's treasury³. Without a thorough ongoing review of South Africa's political economy, particularly in the current context of global financial crises, the ability of the state to break with the apartheid legacy and to fulfil its electoral mandate particularly to poor communities would be severely curtailed⁴.

The introduction of GEAR (Growth, Employment, and Redistribution) policy⁵ by government in June 1996 was a dramatic turn towards aligning the South African economy to meeting the imperatives of the neo-liberal phase of the free market system. The benefits of economic progress were to be attained not through a deliberate programme of redistribution of wealth but of a trickle down of social benefits arising from the anticipated higher economic growth levels. In pursuance of the goal of turning the orientation of the economy towards export markets and in order to comply with the trade rules and requirements of opening local markets to transnational corporations driven by the World Trade Organization, Gear went on an aggressive spate of trade liberalization, the lifting of exchange controls, tariffs and duties, far in excess of what South Africa's commitments in trade agreements actually required. This had the effect of exposure of the economy towards international competition without all the necessary economic anchors and conditions to compete. Gear was introduced in a context where the economy was in decline. Every phase of economic development goes through a crisis, and then redefines its new path towards the next upturn. In doing so, it lays new basic rules and basic features of accumulation that delineate it from previous stages of development⁶.

Whilst Gear policy had promised 6.5% growth, the creation of 1 million jobs per year and improved service delivery⁷, in reality Gear achieved a reversal of some of these objectives particularly in terms of social costs that are associated with its premises. It became an economic platform for the new phase of growth based on lean state, lean production, labor flexibility, financial speculation, a low rate of labor absorption, low productive investment, and an emphasis on technological innovation and services as drivers of economic growth. Between 1997 and 2006 the country's fiscal deficit, declined from 7% to 0.3% as a result of measures instituted by treasury under the Ministry of Finance. However, this was associated with deep cuts in social expenditure and the impact was particularly felt at local government level public service institutions where state / citizen relations were transformed into state /client relationship, resulting in commodification of basic services.

At the same time, this period of social austerity was inversely accompanied by generous concessions to business with cuts on company tax from 40% before 1994 to less than 30% by 2007, allowances for capital flight and other incentives for business. The impact of inflation targeting aiming at maintaining inflation between 3 and 6% on unemployment has been argued to be significant with over a million job losses since introduction of the GEAR. Economic growth was above 5% in 2005, 2006, and 2007. The last time the South African economy grew by 5% or more was in 1984, when economic growth had been 5.1%. Whilst the targeted 6.5% economic growth rate was largely achieved, all credible research confirms that such growth has come with deepening income inequalities⁸ and an unemployment rate unequalled in the world.

³ Annual Budget speeches, 1994-2006 shows incremental allocations particularly in the area of health and education. However in real terms, these increased allocations get absorbed in other operational items such as labour costs and by the process of restructuring in context of unresolved legacy of apartheid which reduces impact on direct benefit by communities.

⁴ The 2005 UN Development report indicate that progress by the state to address unemployment and delivery of services was slower than could be achieved. It pointed out at the rate of inequality, human development index and the declining life expectancy ratio had fallen. Government slammed this report as not representing the real situation in South Africa.

⁵ Gear document, GCIS, 1996.

⁶ Monthly Review, March 2000

⁷ Gear document, GCIS, 1996.

⁸ Labour Resources Centre, Labour survey, 2006

According to the Institute of Race Relations annual *South Africa Survey*⁹, the number of unemployed South Africans, using the strict definition of the unemployment, increased from nearly 2 million to 4.3 million people between 1994 and 2007, representing an unemployment rate increase of 20% to 25.5%. Using the expanded definition of unemployment, the number of unemployed people increased from almost 3.7 million people to 7.8 million people in the same period representing an unemployment rate increase of 31.5% to 38.3%. Unemployment peaked in 2003 but has been more or less constant since 2004.

Although some reports suggest that “government is winning the battle against joblessness” (see *SAIRR Fact Sheet - Unemployment still high across all provinces - 24th April 2008*), it is still evident that (a) rates of unemployment are unacceptably high, no matter which definition is used; (b) unemployment is not declining in the Western Cape – if anything, it is rising; and (c) recent statistics indicate an upward turn in unemployment nationally and in the Western Cape

Unemployment still high across all provinces
(SAIRR Fact Sheet 24 April 2008)

South Africa’s unemployment decreased in 2007, in the country as a whole, and in most of the country’s provinces, with the exceptions of KwaZulu-Natal and the Western Cape. Using the strict measure of unemployment, and the expanded measurement, unemployment has fallen; the South African Institute of Race Relations’ annual survey of the provinces has showed. The expanded rate of unemployment takes into account discouraged workseekers, whereas the strict definition of unemployment does not. Discouraged workseekers are those who are willing to work, but have given up actively looking for employment. The inclusion of discouraged workseekers in employment surveys reveals a more comprehensive picture of the unemployment picture in the country.

The strict unemployment rate in South Africa was 23% in 2007. This was an improvement on the previous year’s rate, when unemployment was 25.5%. Only three provinces; the Western Cape, Gauteng and Mpumalanga, had strict unemployment rates below the national average. Strict unemployment in the Western Cape was 17%, Gauteng was 19.5%, and in Mpumalanga, the rate was 22.9%.

All provinces, with the exception of the Western Cape and KwaZulu-Natal, showed decreases in their levels of strict unemployment, as compared to the previous year. The rise in unemployment in the Western Cape could possibly be due to an influx of migrants from the Eastern Cape, while the rural nature of the population, and the high incidence of HIV/AIDS in KwaZulu-Natal, could be the reasons for these increases. Unemployment in KwaZulu-Natal was nearly 30%.

Limpopo and the Northern Cape were the other two provinces with high unemployment rates, at 27.6% and 25.7% respectively.

The expanded rate of unemployment also showed a decrease. In 2007, this measure showed that 35.8% of South Africans were unemployed. This was an improvement on 2006, when 36.8% of South Africans had been unemployed using the expanded measure of unemployment. Four provinces had unemployment rates lower than the national average, when using the expanded rate of unemployment. These were the Western Cape, Gauteng, Mpumalanga, and the Northern Cape.

Limpopo had the highest rate of expanded unemployment in the country, with over half of the province’s population being unemployed, at 52.1%.

⁹ http://www.sairr.org.za/sairr-today/news_item.2008-11-28.9488661622/

As with the strict rate of unemployment, the only two provinces to show an increase in unemployment were the Western Cape and KwaZulu-Natal. The expanded unemployment rate in the latter was 42.8%. North-West was another province to have a high rate of expanded unemployment, at 40.3%.

Although unemployment is still at unacceptably high levels, there are indications that government is winning the battle against joblessness. Decreases in unemployment in almost all provinces, and the country as a whole, indicate that jobs are being created. The challenge is now to accelerate the rate of job growth, and ensure sustainable employment opportunities are created. (*SAIRR Fact Sheet 24 April 2008*)

Unemployment rate rise to 23,5%

– Sapa – May 6 2009 IOL

Growing unemployment will make it difficult for the ANC to meet its target of halving unemployment and poverty within the first two decades of freedom, Cosatu said on Wednesday.

"The incoming ANC government has the daunting task of realising its election promise of creating decent work for all in a climate where the economy is shedding employment at a frightening pace," the trade union federation said in a statement.

The Congress of SA Trade Unions was reacting to a Statistics SA survey released on Tuesday, indicating that the unemployment rate rose to 23,5 percent in the first quarter of 2009 from 21,9 percent in the previous three months.

"Under the 2005 Accelerated and Shared Growth Initiative, government suggested that if economic growth rose to six percent by 2009, it would be possible to cut down unemployment to around two million or 14 percent of the labour force by 2014.

"At its apex of job creation between 2004 and 2006, the economy was only able to generate half a million jobs a year, yet if the current survey is anything to go by, the economy is shedding at least half of that number every three months," Cosatu said.

According to the Pretoria-based agency's quarterly labour survey, a total of 208 000 people living in South Africa lost their jobs between the last quarter of 2008 and the first quarter of 2009.

Losses occurred both in the formal (88 000) and in the informal (96 000) sectors.

Agriculture and private households accounted for the other losses.

"It is alarming that even this sector, which has traditionally offered a minimal degree of livelihood for retrenched workers and those who cannot find employment in the formal sector is now said to be shedding jobs as well," Cosatu said.

With no source of income, workers will turn to family members receiving state social grants, thus exhausting the little money offered.

"Often those who lose jobs in the mines, factories and supermarkets end up in the informal sector where they set up small survivalist enterprises. As more people are thrown out of work they will have to rely on their limited unemployment insurance benefits, and once these are exhausted, on those family members already on the state's grant system," it said.

The increased unemployment rate was also likely to spark tensions in the labour market as employees would start demanding higher wages to counteract the high cost of living while their employers would point to the worsening economic situation as an excuse to curb wage increases, Cosatu said. – *Sapa – May 6 2009 IOL*

Figure 1.

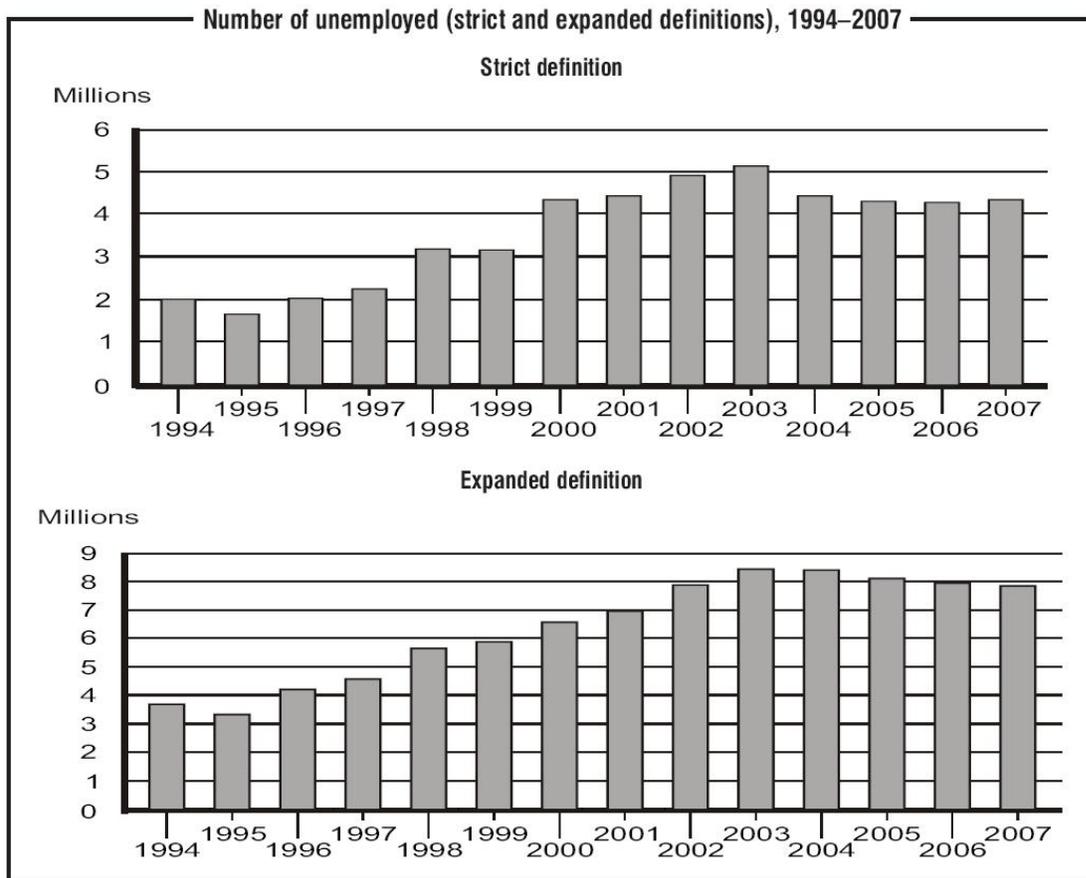
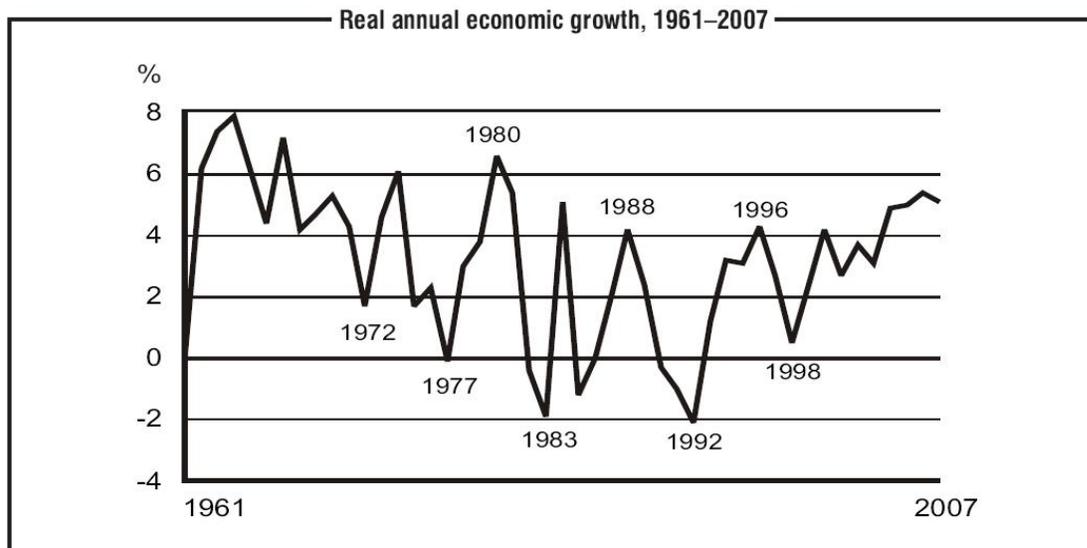


Figure 2.



Source: 2007/08 Survey, p79

In 2007, unemployment rates in the W Cape were 17.2% and 23.9%, using the narrow and expanded definitions, respectively. Ten percent of the Western Cape population (or about half a million people) were living on less than R250 per month and close to 40 000 people surviving on less than \$1 per day (the definition of extreme poverty)¹⁰ in 2007. The poverty index¹¹ varied between 15% and 20% in the Province in the period 1996 to 2007, with the exception that in the Cape Town Metro in 1996, the index was slightly lower than 15%, but this relative “affluence” has probably been negated by in-migration over time to 2007¹². Both unemployment rates and poverty rates in the Western Cape are known to be lower than the rest of the country.

Figure 3.

¹⁰ SAIRR Today: Unemployment and Poverty - An Overview. URL: http://www.sairr.org.za/sairr-today/news_item.2008-11-28.9488661622

¹¹ The Poverty Index used by the Department of Social Development is a composite of 10 household indicators, including the proportion of households headed by women, the proportion of population over 15 years who have not completed St5/Grade 7, the proportion of the economically active who are unemployed (broad definition), the proportion of households without no annual income, the proportion of households sharing one room with at least one other household, the proportion of households classified informal or traditional, the proportion of households without a flush or chemical toilet, the proportion of households who have no tap/piped water inside dwelling or on site, the proportion of households who do not have electricity for lighting purposes and the proportion of households whose refuse is not removed by the local authority

¹² Nesbert Zinyakatira (Department of Social Development). A Glance at Poverty in the Western Cape Province. Presentation to Workshop: “Targeting poverty through IDP,” Saldanha Bay, March 2009

Unemployment rate by province, 2005–07

Province	Unemployment rate ^{ab}					
	Strict definition			Expanded definition		
	2005	2006	2007	2005	2006	2007
Eastern Cape	27.1%	22.1%	25.5%	43.6%	36.9%	42.9%
Free State	30.6%	28.3%	26.4%	39.1%	38.7%	37.5%
Gauteng	22.7%	23.3%	22.6%	34.1%	34.3%	32.3%
KwaZulu-Natal	31.7%	29.9%	29.2%	45.5%	44.0%	42.0%
Limpopo	32.4%	35.6%	32.4%	57.3%	59.0%	53.5%
Mpumalanga	27.4%	27.4%	26.3%	42.1%	39.4%	38.6%
North West	28.8%	31.8%	32.0%	45.6%	45.6%	45.3%
Northern Cape	29.4%	23.5%	26.5%	41.3%	36.3%	36.7%
Western Cape	17.6%	15.9%	17.2%	24.8%	23.0%	23.9%
South Africa^b	26.5%	25.6%	25.5%	40.5%	39.0%	38.3%

Source: 2007/08 Survey, p211

a Unemployed as proportion of provincial economically active population

b Figures should add up vertically but may not, owing to rounding, and owing to the fact that Stats SA disregarded sample sizes smaller than 10 000 as unreliable.

Unevenness of service delivery

Although there have been small gains in reported socio-economic indicators for the Western Cape (See Figure 4. below), these averages mask deep intra-provincial inequities. For example, poverty levels have increased in **West Coast, Cape Winelands and Eden** districts, but have decreased in the **Central Karoo** district between 2001 and 2007, while poverty levels in the Overberg district and Cape Town metro peaked in 2001, but are now dropping by 2007. Rates of hunger differ widely between municipalities with the ratio of hunger experienced in municipalities with the worst rates of hunger being 15 to 20 times higher than that experienced in the municipalities with the lowest rates. Of the 29 municipalities in the province, 9 municipalities appear to demonstrate declining rates of poverty, 15 show increasing rates and for the other 4, the shifts in rates are equivocal. This suggests a mixed picture of both positive and negative developments¹³.

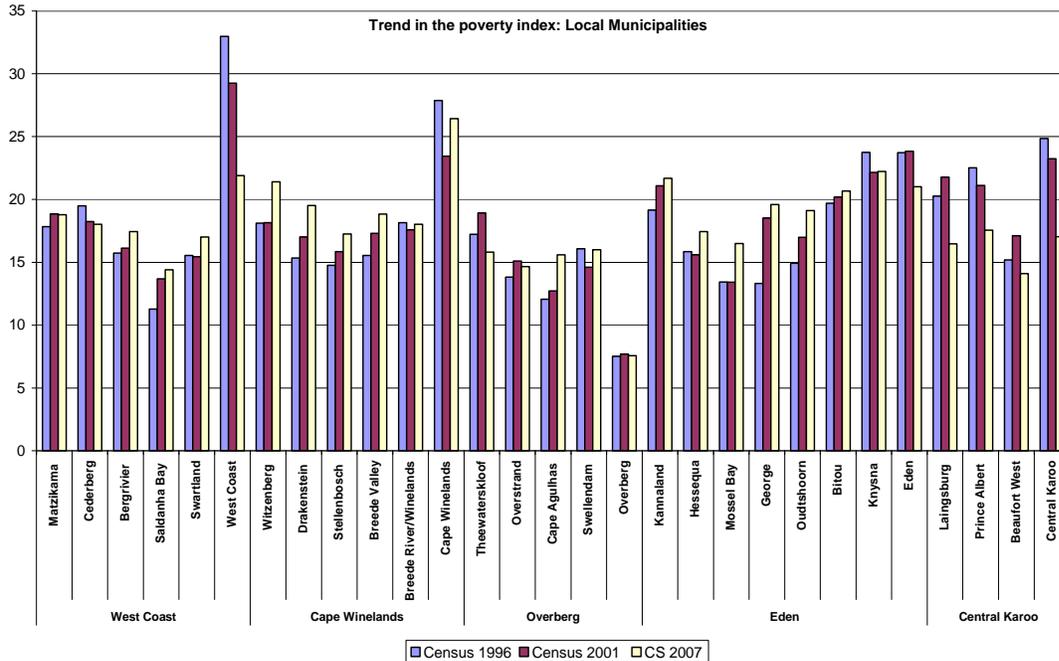
Figure 4. Socio-economic indicators for the Western Cape

	Metro		Provincial	
	2001	2007	2001	2007
% households without weekly refuse removal	5.8%	5.8%	n/a	n/a
% households in informal housing	n/a	n/a	16.2	14.2
% households using electricity for cooking	n/a	n/a	86.5	88.8
% households without electricity	13.20%	11.23%	n/a	n/a
% households with access to piped water	84.6%	95.0%	98.9	98.9
% households with no toilet	n/a	n/a	4.8	3.8
% households with no access to flush toilet	12.7%	7.2%	n/a	n/a
% households with telephone (telephone in dwelling or cell phone)	n/a	n/a	79.3	83.5

¹³ Nesbert Zinyakatira (Department of Social Development). A Glance at Poverty in the Western Cape Province. Presentation to Workshop: "Targeting poverty through IDP," Saldanha Bay, March 2009

Source: Health Systems Trust, 2009¹⁴ and City of Cape Town, 2009¹⁵

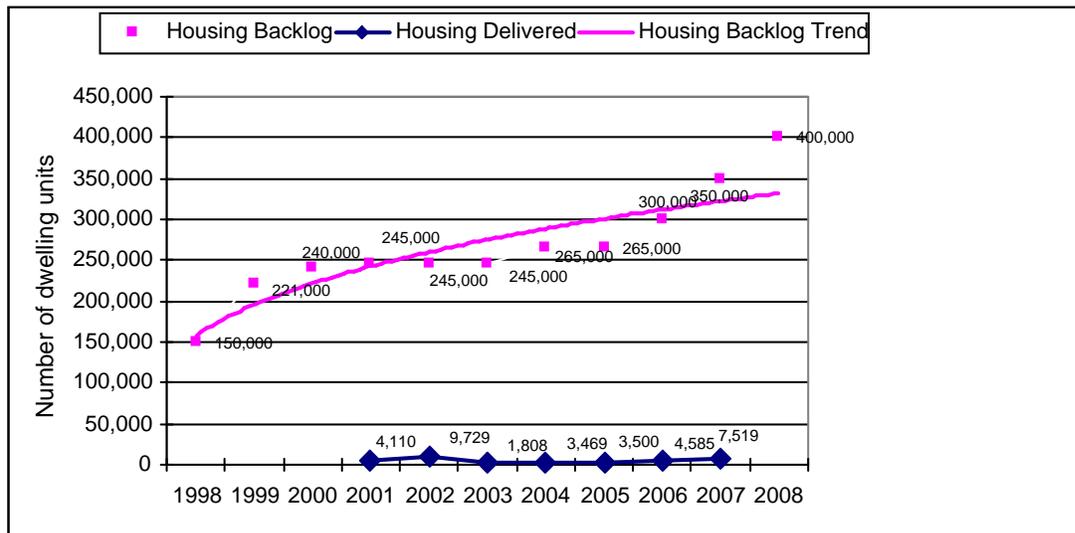
Figure 5.



Source: Nesbert Zinyakatira, 2009

In particular, housing provision has failed to keep pace with need with the backlog in 2008 estimated at approximately 400 000 housing units (City of Cape Town, 2009).

Figure 6. Housing backlog in Cape Metropole, 2009



Source: City of Cape Town, 2009

¹⁴ Barron P, Roma-Reardon J (Eds). South African Health Review 2008. Health Systems Trust, Durban, 2009.

¹⁵ City of Cape Town. Poverty Alleviation in Cape Town through IDP Programmes. Provincial Workshop: "Targeting Poverty through IDP" March 2009.

In response to these inequalities, several service delivery protests have taken place (for example, see "Eskom to blame, not the ANC"). These protests were either attributed to being a result of lack of local government capacity, lack of commitment of local officials to service or were simply works of urgent provocateurs. No acknowledgement was made of the problem as the outcome of Gear, the economic policy framework of the democratic government.

Further, in the heat of political party election campaigning in the 2009 elections, several government initiatives such as project consolidate, expanded public works programs, and the Social Relief of Distress Fund were used as electioneering strategies to win votes (see "Misuse of State Funds for Political Reasons" below).

Eskom to blame, not the ANC - Plato

May 20 2009 at 02:25PM Cape Argus

By Lindsay Dentlinger

Cape Town Mayor Dan Plato says Eskom's inability to electrify the informal areas of Khayelitsha is the spark that ignited service delivery protests earlier this month.

Plato believes Eskom's removal of illegal electricity connections was the cause of the outrage of hundreds of people who did not understand that the city was unable to provide them with electrical connections.

"If Eskom hadn't removed those connections, my take is that we wouldn't have seen such uprisings," Plato told his mayoral committee on Tuesday.

'This is the difficulty the city is facing'

The City of Cape Town has about 680 000 electricity customers and Eskom has 137 000. Many informal parts of the city not yet electrified fall within Eskom's supply area.

On Tuesday the committee agreed to support Eskom in its application to the Department of Minerals and Energy for finance through the Integrated National Electrification Programme, to electrify more than 50 000 dwellings, including all informal settlements in Khayelitsha.

In a report to the committee, the city notes: "Over the last decade the city made steady progress with the electrification of the informal dwellings within its licensed area of supply.

"However, progress in the Eskom-licensed area of supply has been less than satisfactory."

As the service authority for the distribution of electricity, the council is required to formally approve the electrification of informal settlements in the Eskom-licensed area of supply.

The city has compiled a list of settlements approved for up-grade, including 7 905 houses in Monwabisi Park, 4 929 houses in Silvertown, more than 2 000 houses in Du Noon, as well as homes in Crossroads, Phola Park and Wag 'n Bietjie.

Plato said that because most informal settlements were in flood-prone areas, and at least 1 500 Khayelitsha shacks were on the road reserve, Eskom would be defying policy if it electrified the areas. It was largely those living in the road reserves who had "run amok" in protest over service delivery.

"This is the difficulty the city is facing. It is a dramatic service-delivery issue that the City of Cape Town has no control over. Other political departments must take note of what's happening," said Plato.

On earlier claims by Helen Zille that the uprisings were politically motivated, Plato said today that he was only focusing on service delivery issues of the affected communities.

"I will leave the political stuff for other people," he said.

Plato is due to meet Khayelitsha residents tonight.

Committee member for utilities Clive Justus said that in its response to the National Energy Regulator (Nersa) on Eskom's application for a 34 percent electricity tariff increase, the city would ask for authority to provide electricity in some of the areas under Eskom's control.

Eskom spokesperson Fani Zulu said the power utility had been compelled to disconnect illegal connections, or face liability for injury.

He said Eskom relied on government funding to electrify the areas, and for municipalities to identify them.

Misuse of state funds for political reasons

As we report in detail on this matter in our previous report, we still continue to receive reports of the misuse of state funds for electioneering purposes. These have been reported in Limpopo, Eastern Cape, Western Cape and Gauteng. The alleged abuse of the Social Relief of Distress (SRD) grant and the distribution of food parcels by some politicians campaigning for support ahead of the elections continue to be reported throughout the country. The SRD grant is designed to provide temporary relief to those in dire material need, it is a bridging mechanism for families who have temporarily fallen on hard times or who are waiting for grants or government programmes for which they are eligible.

The Election Monitoring Network urges government departments to ensure that proper procedures are followed to identify the beneficiaries of social assistance such as state grants and food parcels by following a process that ensures that all those individuals and families who are desperately in need of assistance actually get it.

<http://www.idasa.org.za/gbOutputFiles.asp?WriteContent=Y&RID...>

Access to health care

The Infant Mortality Rate (IMR) and the Under-5 Mortality Rate (U-5MR) are generally taken as composite indicators of poverty, reflected both the influence of social determinants of health as well as access to timely and effective health care for children. The Western Cape had the lowest U-5MR in South Africa at 46 per 1 000 live births in 2003¹⁶ and infant mortality in the City of Cape Town declined from 22.3 per 1000 live births in 2005 to 19.2 in 2007¹⁷. However, despite having the lowest under-5 mortality rate in the country, the Western Cape is among the most unequal provinces, with young child mortality varying by a factor of 3 between the worst and the

¹⁶ D Sanders, L Reynolds, B Eley, M Kroon, H Zar, M-A Davies, T Westwood, P Nongena, T van Heerden. Western Cape Burden of Disease Reduction Project. Volume 7 of 7. Decreasing the Burden of Childhood Disease. Final Report. Provincial Government of the Western Cape, Cape Town, 2007.

¹⁷ City of Cape Town, 2009

best areas in 2002 (cited in Sanders et al, 2007). There is no evidence to suggest that such inequalities have been reduced since 2005. Indeed, there is some evidence to suggest inequalities in access to health care have increased in the Western Cape in this period.

Health indicators for the province for the period 2006 to 2009 are hard to ascertain and trends cannot easily be inferred from data comparing 2006 to 2005, or even, at best, 2007 to 2005. However, in general, it would appear that the picture is mixed, with some indicators declining, others increasing and a number remaining more or less unchanged. (See table below)

Figure 7. Health indicators for the Western Cape 2005-2007.

Health Indicator	<2005	2005	2006	2007
Infant Mortality Rate per 1000 live births	43.5 (in 2003)		26.0	25.3
Neonatal Death Rate per 1000 live births	5.4 (in 2003)		6.0	
Perinatal Death Rate per 1000 live births	26.6 (in 2004)	25.4	25.2	
Stillbirth Rate per 1000 live births	18.0 (in 2004)	18.8	19.2	
Syphilis Prevalence amongst pregnant women (%)		4.0	1.9	5.7
TB Incidence per 100 000	988 (in 2004)	1037	1031	1008
Antenatal HIV prevalence (%)	15.4 (in 2004)	15.7	15.1	12.6
Road accident fatalities per 100 000	31.3 (in 2004)	34.1	34.7	34.0

Source: South African Health Review, 2008

Perinatal and Early Neonatal Mortality Rates remained more or less unchanged from 2005 to 2006, as did fatalities from road traffic accidents. TB rates remain high in the Western Cape. The only reason why the Western Cape has been overtaken by Kwazulu Natal in its TB rate is because of high co-infection rates with HIV and the high background HIV seroprevalence in KZN. Nevertheless, the Western Cape TB incidence rate is still about 30 to 40% higher than the national rates, reflecting poor social and living conditions and increasing HIV prevalence in selected clusters in the province.

Figure 8. Health care indicators for the Western Cape 2005-2007.

Health Indicator	<2005	2005	2006	2007
TB cure rates (%)	70.1 (in 2004)	71.9	77.3	n/a
TB interruption rates (%)	11.9 (in 2004)	11.1	9.7	n/a
Smear conversion rates (%)	58.0 (in 2004)	60.7	66.9	n/a
Successful completion rates (%)	78.9 (in 2004)	79.7	82.0	n/a
Termination of Pregnancies performs	11157	15149	13314	13959
Delivery in a facility (%)	81.7 (in 2004)	64.7	92.4	n/a
Male condom distribution rate	14.4 (in 2004)	17.1	30.9	n/a

Source: South African Health Review, 2008

Although cure rates for TB were reported as showing modest improvements (SAHR 2008), the Western Cape has also seen a significant rise in Drug Resistant TB case. In 2007, the Western Cape was reported to have 1200 cases of Drug Resistant TB alone, approximately 35% of all DR TB cases in the country¹⁸. Given that Drug Resistant TB is usually a problem associated with incomplete treatment of TB, the reported cure rates for TB may well be overestimating the real situation. The Western Cape has been so overwhelmed with drug resistant TB that the Department has had to go to court to order a recalcitrant patient to return to hospital for confinement because of risks to others. However, it is obvious that there will not be sufficient hospital beds for a large patient load of drug resistant TB patients so community-based

¹⁸ Department of Health. National Tuberculosis Programme. 4 July 2007. Accessible at URL: http://www.bullion.org.za/Departments/Health/Downloads/NTP%20mining%20workshop%202007.ppt#264,1,NATIONAL_TUBERCULOSIS_PROGRAMME.

treatment strategies will be a necessity. The Western Cape Health Department is piloting one of two such community based models of treatment in Khayelitsha at present.

The distribution of male condoms has increased substantially from 17% in 2005 to 31% in 2006. This is probably due to a concerted effort made in Khayelitsha by district managers to promote distribution and uptake of condoms by clients visiting local facilities.

Most women (92%) women delivered in a facility in 2006 indicating improved access. However, the provision of Termination of Pregnancies declined from 15149 in 2005 to 13959 in 2007.

Per capita health expenditure (adjusted for inflation) increased from R 376 in 2005 to R 428 in 2007 (14% increase) (Equivalent national increase was 16%). The ratio in PHC expenditure from district with highest expenditure to lowest expenditure went from 1.76 in 2005/6 to 1.64. Over 30% of patients in the Cape Metro who were ill and consulted a health worker in 2006 cited long waiting times as a problem (GHS, 2006).

Figure 9.

Public Sector personnel in the Provincial Health Services in the Western Cape						
POSTS	2005	2006	2007	2008	% change 2005 to 2008	Percentage of all health professionals registered with their council working in Provincial Health Services
Dental practitioners	125	120	108	121	-3.2%	9.94%
Dental specialists	18	13	2	1	- 94.6%	
Dental therapists	2	2	3	3	+50%	100.00%
Enrolled nurses	1699	1744	1866	2035	+19.8%	41.10%
Environmental health practitioners	10	11	8	8	-20%	1.81%
Medical doctors	1244	1341	1246	1418	+14%	17.10%
Medical researchers	51	46	24	29	-43.1%	
Medical specialists	1003	1082	1221	1193	+18.9%	
Nursing assistants	3789	3826	3865	4017	+6%	
Occupational therapists	83	100	104	105	+26.5%	13.00%
Pharmacists	257	278	301	324	+26.1%	15.23%
Physiotherapists	98	114	112	123	+25.5%	8.66%
Professional nurses	3830	3959	4199	4615	+20.5%	31.30%
Pscyhologists	58	60	71	65	+12.1%	5.28%
Radiographers	358	392	397	401	+12.0%	35.80%
Student nurses	219	83	13	0	-100%	
All Health Professionals	12844	13171	13539	14458	+12.6%	
VACANT POSTS (%)					% change 2005 to 2008	% change 2006 to 2008
Medical doctors	n/a	12.6	14.8	17.4	n/a	+ 38.1%
Professional nurses	n/a	22	23.8	31	n/a	+ 40.9%

All health professionals	8.1	16.9	18.7	23.3	+187%	+ 37.8%
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Source: South African Health Review, 2007 and 2008.

Overall, data suggest an increase in health professionals in the public sector services in the Western Cape over the period 2005 to 2008. The exceptions are for small occupational categories, including dental specialists, and medical researchers.

However, it is also notable that the percentage of vacant posts escalated dramatically during the same period. This must indicate that although the province is budgeting and earmarking posts to cope with rapidly growing demand for health care, it is not able to fill posts desperately needed in the province. This is borne out by some of the case studies cited in the next section.

Progressive Realisation of Children's Health Rights

Conditions in health facilities often give us a good idea of what goes on in the areas and communities that the patients come from. They also provide good insight into prevailing standards of health care, both within the facility and elsewhere.

The Red Cross War Memorial Children's Hospital (RCCH) provides a teaching platform for the Health Sciences Faculty of the University of Cape Town. It provides training for various categories of health professionals including nurses and future doctors and specialists.

It is a relatively well-resourced institution in comparison with other public sector health facilities, and it is located in the province with the lowest under-5 mortality¹⁹ rate in the country.

This short document describes conditions in the outpatient ward at the RCCH as an indicator of progress in implementing children's constitutional rights.

Trends in admission to the Ward S11 (A8 – General, A9 – Rehydration) at Red Cross War Memorial Children's Hospital

The Short Stay Ward, S11, at the RCCH is the main ward for sick children from Klipfontein, Khayelitsha and Mitchell's Plain sub-districts in Cape Town. About 18% of patients come from beyond those areas.

Since S11 only admits children who are too ill to be treated at home, the spectrum of disease in the ward reflects the pattern of severe childhood illness in the communities from which they come.

Children stay in S11 with their caregivers [usually their mothers] until they are well enough to go home to continue treatment, or – if they need more prolonged hospital treatment – until an in-patient bed can be found for them at RCCH or another hospital. In theory their stay in S11 should not be more than 24 hours, but in practice it can be as long as 4 – 5 days because of a general shortage of paediatric beds in the public sector. The ward is often overcrowded with more than 100% bed occupancy.

The ward has 2 sections, A8 and A9. A8 is used mainly as a rehydration facility for dehydrated children with diarrhoea due to gastroenteritis.²⁰ A9 provides short-term care for children with other diseases who are too ill to be treated at home.

¹⁹ Under-5 mortality refers to the probability that a child will die before her or his 5th birthday, expressed per 1000 live births. The U-5MR is an important indicator of a country's state of development.

²⁰ Diarrhoea due to gastroenteritis is a major cause of death in children under 5 years old globally. It kills when the child becomes severely dehydrated due to the loss of water and salts from the body. Children with gastroenteritis are admitted to A9 only if they are dehydrated or at risk of dehydration.

Figure 11 shows how many patients were admitted to S11 between 2001 & 2008.

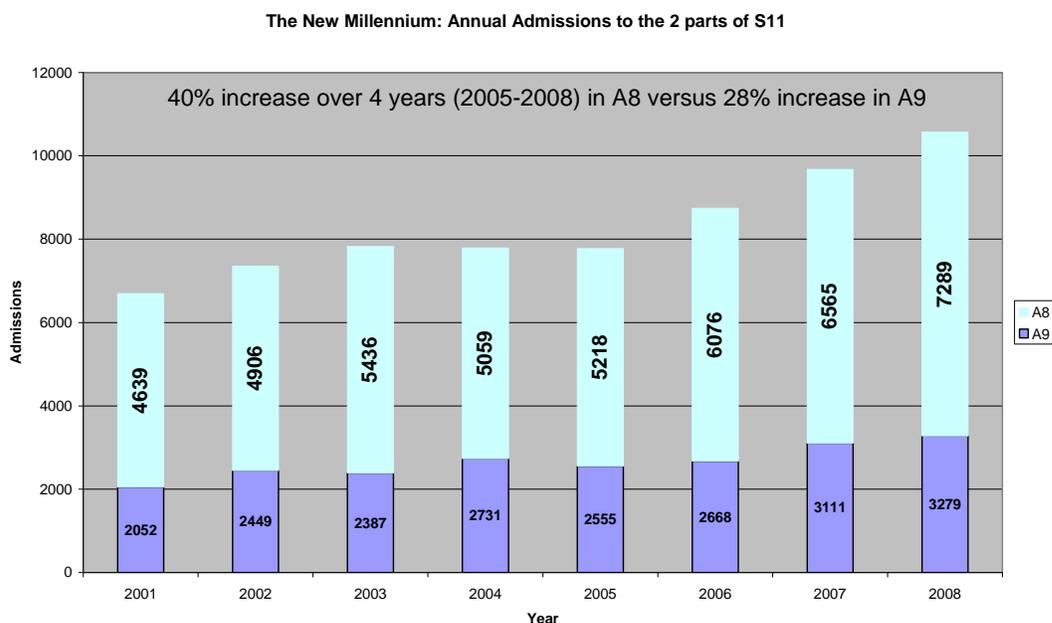


Figure 11: admission statistics for ward S11

Over the 7 years between 2001 and 2008 overall admissions increased by 58%, or by 8.3% per year on average. Admissions for gastroenteritis increased by 37% (5.3% per year), while admissions for other diseases increased by 57% (8.2% per year).

Between 2003 and 2005 the rate of admissions remained static, but in the 3 years since 2005 there has been a more rapid rise in the annual rate of admissions than before 2003. Overall admissions increased by 36% between 2005 and 2008 – an average increase of 12% per year. Admissions for gastroenteritis are up by 22% (7.2% per year), while admissions for other diseases are up by almost 40% (13.2% per year).

What the figures show

- Both diarrhoea and non-diarrhoea admissions are increasing.
- The rates of increase of both have been greater since 2005 than they were before 2003.
- Non-diarrhoea admissions are increasing faster than diarrhoea admissions.

A concerted attempt over the past 4 years by the Health Department to mitigate the cases of diarrhoea that require admission through earlier and more aggressive treatment at primary level may account for the relatively lower rate of increase in diarrhoea admissions.

However, even these sterling efforts have not stemmed the tide of severe diarrhoea in young children. At the same time admissions from other diseases continue to increase at an alarming rate. This indicates that the underlying determinants of childhood illness, including diarrhoea, are not improving or that they are getting worse. Global experience indicates that these determinants include, but are not limited to, poor water and sanitation, poor food hygiene (no home refrigeration), poor nutrition – leading to reduced immunity to infection, overcrowding in households, and smoky and poorly ventilated homes.

Why is there an increase in admissions of very ill children?

The most likely explanations for the growing numbers of admissions for severe childhood illness in the City of Cape Town are (1) an increase in the population, and (2) deteriorating child health, within the drainage area.

An increasing child population.

The 2007 Community Survey Analysis for Cape Town found that the population of Cape Town grew by 20.9% since Census 2001 and 36.4% since Census 1996. While the South African population increased by 8.2% between 2001 and 2007, the Western Cape was the province with the largest increase (16.7%) with 80.2% of the population increase occurring in Cape Town.²¹

The accelerated growth in Cape Town's population has been overwhelmingly among the black African group (Figure 12), and in the informal periurban settlements such as Khayelitsha. These areas are the source of the overwhelming majority of Ward S11 admissions.

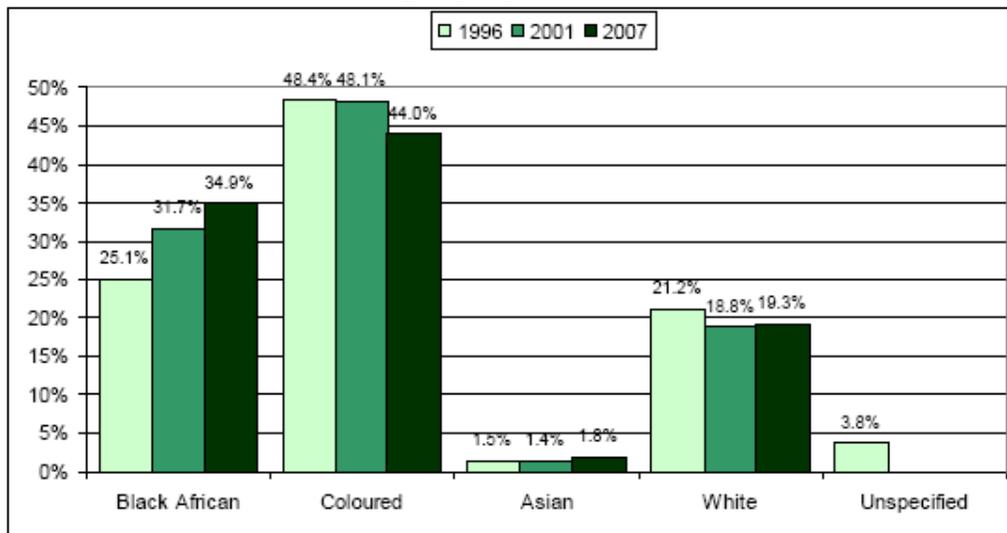


Figure 12: inward migration to Cape Town by population group

Inward migration, particularly from the Eastern Cape, but also from outside South Africa accounts for a large proportion of the population increase. About 27% of the immigrants are children under the age of 14, with 14.4% being under 5 years old. In addition to inward migration there has been a 10 to 15% per year increase in the the numbers of births in the Cape Town Metropolitan area over the past 3 years.

Deteriorating child health, resulting in more childhood disease.

Most of the children come from Khayelitsha and other informal settlements – areas where poverty and lack of adequate clean water and sanitation, as well as inadequately ventilated and overcrowded housing, create conditions that make children highly vulnerable to severe illness, including diarrhoea, pneumonia and tuberculosis.

Water:

The Community Survey analysis found that by 2007 over 99% of households in all race groups had access to piped water. Piped water was available in the dwelling in 80.5%, in the yard in 10.6% and outside the yard in 8.4%.

Among Black African households, however, only 52.6% had piped water in the dwelling by 2007. In some areas up 90 to 100 households, or 300 to 400 people share a single standpipe.

²¹ Karen Small. 2007 Community Survey Analysis. Strategic Development Information and GIS Department, Strategic Information Branch, Cape Town. October 2008

Research done in several parts of the world indicate that, where a water source is distant or shared amongst many, water usage declines. Having access to sufficient volumes of water for personal and food hygiene reduces the risk of water-related diseases such as diarrhoea and skin infections and increases quality of life.^{22 23}

Sanitation:

Households without adequate toilet facilities are more vulnerable to diseases and epidemics.²⁴
²⁵ Pollution of waterways and wetlands increases and this puts a large percentage of the population at risk of contracting water-borne diseases. These increase the need for additional health care facilities.

In 2007 6.9% of Black African household in Cape Town used bucket toilets, while 9.1% had no toilet facilities.

It is therefore highly likely that there is a rapidly growing population of small children in the Cape Town Metropolitan Area who are highly vulnerable to severe illness. In addition, the determinants of child health in specific areas of the metropolitan area are not improving fast enough, and conditions that make children sick persist. As a result, Cape Town's children are getting sicker, and the load on the health system is growing.

What do these trends tell us about the implementation of the rights in the Bill of Rights?

Not only are Cape Town's children getting sicker, but the impact of the increasing admissions is also putting severe stress on the hospital staff. These factors are damaging the quality of patient care. This has implications for the following rights in the Bill of Rights:

1. *Section 28 (1) Every child has the right ... (c) to basic nutrition, shelter, basic health care services and social services.*

Though the RCCH is seen by some as a tertiary referral hospital, the majority of patients in Ward S11 are receiving the kind of acute care that should be available within the community: oxygen, antibiotics, and correction of dehydration. This is basic health care.

Furthermore, if 'basic health care' includes safety in the clinical setting, then there is an additional argument supporting the idea that children in S11 are not enjoying the right to basic health care. They are at high risk of medical errors, and of hospital-acquired infection, as will be shown below.

2. *Section 28 (2): A child's best interests are of paramount importance in every matter concerning the child.*

The intention here is the same as that contained in Article 3 of the UN Convention on the Rights of the Child. Since South Africa ratified the UNCRC in 1995, we are bound to it by international law.

Article 3 of the UNCRC gives meaning to the 'best interests' principle. Inter alia, it specifies that

²² Esrey S., Potash J., Roberts L., Schiff C. 1991. Effects of improved water supply and sanitation on ascariasis, diarrhoea, drancunculiasis, hookworm infection, schistosomiasis and trachoma. *Bulletin of the World Health Organization* 60:609-621.

²³ Huttly S., Morris S. and Pisani V. 1997. Prevention of diarrhoea in young children in developing countries. *Bulletin of the World health Organisation* 75(2): 163-174.

²⁴ Billig P., Bendahmane D., Swindale A. 1991. Water and Sanitation Indicators Measurement Guide. *Food and Nutrition Technical Assistance Project*, Washington D.C.

²⁵ Esrey S., Potash J., Roberts L., Schiff C. 1991. Effects of improved water supply and sanitation on ascariasis, diarrhoea, drancunculiasis, hookworm infection, schistosomiasis and trachoma. *Bulletin of the World Health Organization* 60:609-621.

States Parties shall ensure that the institutions, services and facilities responsible for the care or protection of children shall conform with the standards established by competent authorities, particularly in the areas of safety, health, in the number and suitability of their staff, as well as competent supervision.

It has become impossible to maintain adequate safety measures and standards of care in ward S11 (and in other parts of the hospital).

Despite clear evidence of progressive increases in the clinical load at the RCCH (as well as other health care facilities) there has been a steady fall-off in the staff numbers, including nurses, doctors, physiotherapists, social workers and others. The reasons include poor working conditions, poor pay, job dissatisfaction, falling morale, and intolerable levels of stress. Several staff members have become ill due to stress-related conditions, and it is becoming difficult to recruit and retain staff, including doctors. There are a number of vacant posts.

Facilities are crowded with patients too close to each other to prevent infections from spreading from patient to patient and even to staff members.

3. *Section 24 (a): Everyone has the right (a) to an environment that is not harmful to their health or well-being.* As a result of overcrowding and understaffing, children in Ward S11 find themselves in an extremely dangerous environment. The following paragraphs illustrate this.

Between February and May 2009, 10 children in Ward S11 were found to have become infected with a highly antibiotic-resistant organism, ESBL Klebsiella. The evidence shows that at least 8 of these patients acquired the infection in hospital. Two have died as a result of the infection. A senior paediatrician at the hospital says

'Overcrowding has reached intolerable limits in S11 – 2 children have died as a direct result of this infection and many others suffer unreported injustices. ... This is surely enough to convince management that too many patients, too few staff, not enough space is a time bomb that has already gone off.'

To be fair, the management of the RCCH is highly concerned about safety standards in the institution and the risk of hospital-acquired infection in particular. It is, however, practically impossible to correct both the overcrowding and understaffing within the current financial constraints and the escalating patient load.

Conclusions²⁶

This submission considers progress in the realisation of social and economic rights from the perspective of experiences at one of the nation's better functioning health care institutions. It shows that broad progress in implementing the social and economic rights in the Bill of Rights that are essential for good child health is disappointing. As a result many of South Africa's children still live in conditions that make them sick, and when they do get sick, their access to good quality basic health care is extremely limited.

The constitutional rights of children to basic nutrition, shelter, basic health care services and social services are not conditional on the availability of resources [in my understanding as a non-lawyer at least] and there should be no delay in implementing them.

Inside the health care system it is clear that very little cognisance is given to the principle of 'the best interests of the child' in the way that safety standards and quality of care in its institutions are increasingly compromised as a result of declining staff numbers having to deal with growing numbers of very ill children in inadequate and overcrowded facilities.

²⁶ I, LR, write this as a non lawyer; it is based on my somewhat limited understanding of these matters.

Thus the most vulnerable children – those from impoverished communities with the least access to nutrition, clean water and adequate shelter – are treated in increasingly unsafe, crowded and under-resourced public health facilities when they get sick. This is the very antithesis of the human rights-based approach to service delivery required by the constitution. A rights-based approach means that the most vulnerable and the most needy should be given the highest priority in resource allocation.

Children's socioeconomic rights should at least never be retrogressive. The failure to respond adequately to the challenges posed by demographic trends means that some children will experience retrogression of their rights. This applies to the right to social services (where social worker posts are frozen or moved), and to basic health care (when the need for care outstrips availability and access, and where safety standards cannot be maintained).

The scale of inward migration to the Western Cape suggests that there is an even greater lack of implementation in other provinces, particularly the Eastern Cape.

The global economic crisis with its trail of rising unemployment and increasing poverty, plus the looming impacts of climate change on the poor and vulnerable, will exacerbate the difficulties in meeting socioeconomic rights by increasing the material needs necessary to implement them and decreasing the availability of resources to state and non-state actors.

Outsourcing of healthcare services

The Zanempilo Trust Health Program's overall aim is 'to promote and improve the health of disadvantaged communities in the Western Cape'. It is dedicated to the delivery of community based Primary Health Care (PHC) services in the Western Cape. Its main purpose is also to advocate for the official Government recognition of the role of Community Health Workers in PHC service delivery.

The Program is currently funded the Western Cape Department of Health (WCDOH), the Department of Social Development (DSD) and private corporation funding. PHC services are delivered through community health workers (CHW's). In its current form, the program began in 1998 and is based in Mitchell's Plain and Khayelitsha Health districts. It comprised a coming together of previously independent health NGO's established during the apartheid period and funded directly by mostly foreign donors, such as the Kellogg Foundation and the European Union. Zanempilo faced funding difficulties following the EU decision to redirect all NGO funding via government. Delays in funding via government forced the program workers to volunteer for a period of two years, between 2002 – 2004, without any compensation.

The WCDOH decided to use the EU funding for home based care, which forms only a small part of Zanempilo's work. The WCDOH funds stipends for 4 hours a day for Community Based Carers (CBC's) to care for patients diverted to community level care, thus reducing hospital admissions. Up until 2007 CBC's were additionally funded for several extra hours to provide IMCI (Integrated Child Health Services). However, this service is now provided by the CBC's within the same four hours they spend on HBC and with no extra pay. The Department of Social Development funds a program for Orphans and Vulnerable Children, in order to strengthen the capacities of families and communities to care for children. It insists that as part of an economic strategy, separate Social Agents undertake this work for 4 hours a day and receive a stipend. CBC's are not allowed to take on this extra work. Delivery of quality care through the same carers delivering integrated of services is compromised in this process. Whereas all stakeholders recognise in theory that health is multifactorial and that good health programmes have to work intersectorally, it appears that intersectoral action on the part of government is

extremely difficult to achieve and that such obstacles can seriously hinder progress on realising the right to health.

The strengths that the Zanempilo CHW program developed internally include:

- CHWs are an essential and recognised component of PHC internationally
- Long- established and experienced partner organizations with relevant programs, serve the needs of poorest communities.
- Previously the organization had an appropriate, pro-active, comprehensive and after hours service, with accepted, accessible, and affordable services
- It has always complimented and co-operates, especially post-'94, with government clinic services
- Communities strongly support and value CHW service provision

However, neither government department (Health and Social Services) provide funding to maintain existing infrastructure and accounting services and give minimal funding to administration and management costs. As a result existing resources may potentially be wasted or lost in the process and it is difficult to maintain viable management and accounting services. It is hard to understand how government can expect the cost of overheads to community based non-profit organizations to run HBC programmes should be absorbed elsewhere in the non-profit sector.

The difficulties faced in this manner of operation by Community Based non-profit organisations, which previously received direct funding and delivered holistic integrated health services are as follows:

- Government has lacked an integrated District Health Management approach in its relationship with the program, involving the co-ordinated planning and co-operation of all health services via District Health Management Committees. This makes it difficult to develop effective, sustainable Community Health Centre.
- Advocacy and Community Involvement are best integrated with other management responsibilities and programmatic work should have a comprehensive approach and be delivered by one cadre of worker, rather than vertical and fragmented services being delivered by a myriad of separate workers, as is currently dictated by government policy. The need for comprehensive programmes is at the heart of the Primary Health Care approach and is central to realizing health as a right.
- Government funding has driven expansion rather than consolidation of the program seeking to increase numbers of HBC workers rather than ensuring a high quality service grounded in PHC principles.
- It has been difficult to develop shared services with government as government has insisted on separate service provision for example for ARV monitoring and adherence rather than expanding the services of existing CBC's.
- The scant funding for program management has made it impossible to develop a strong, integrated management team, and management systems, particularly for reporting, monitoring, performance management and appraisal. This has made it difficult to build a performance and learning focused culture based on ongoing sharing, reflection, evaluation, and continuous improvement, ie. a culture of committed service within this context.
- While training has been available to CBC's there has been no focus or resources provided to improving service quality via better management and ongoing skills development for managers, co-ordinators and administrators.

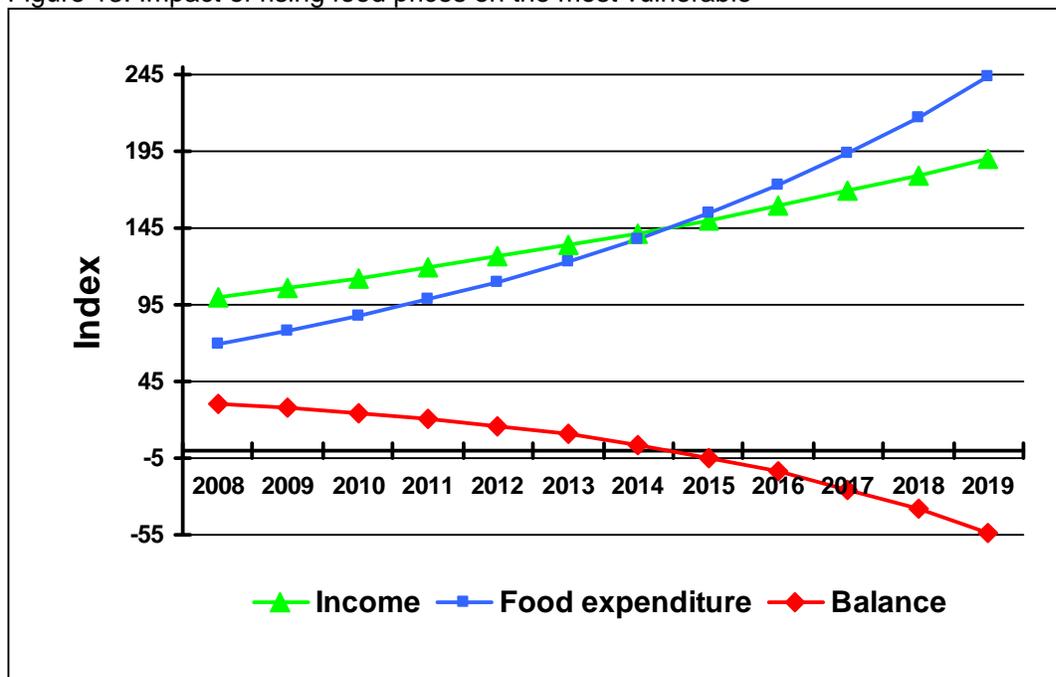
- Long periods of disruption to funding through bureaucratic delays in government contract signing, financial reconciliation and funding. This has led to tensions among staff and lowering of morale, confusion and distraction of management capacity. Recently, at end February 2009 the program was left without funds to pay its staff and meet its other financial obligations. The program used its own reserves to pay out HBC stipends at end March. However, at the end of April 2009, program staff, who earn meager stipends, were without even this small stipends for a period of two weeks while waiting for the next allocation of funding to be paid by government. They found themselves unable to buy food to feed their families and had to try and loan money from other poor community members. This leads to despondency and impacts extremely negatively on their ability to service their communities. There has been much publicity in the press of late of dysfunctional and user-friendly Community Health Centre. Community Health Centres would function best when their staff are supported and nurtured by program NPO/CBO staff in local areas.

These serious issues need to be urgently and seriously addressed if the primary care services as a whole are to operate effectively to implement improved and accelerate service delivery in increasingly impatient disadvantaged communities.

Impact of price-fixing on the right to food and nutrition

It has been widely reported that large corporations (such as Tiger brands, Foodcorp, Pioneer Foods and Premier Foods, Danone, Parmalet and Clover dairies) dominate food and dairy production and some have been found guilty of colluding in anti-competitive practices. Their practices have been said to have contributed to rapid rises in food prices. Food inflation has risen much faster than general inflation rates (12% versus 6%, respectively)²⁷. If this trend continues unaddressed, large numbers of families will be tipped into negative household food security balance (See figure 13. below). Evidence is already emerging of such adverse impacts.

Figure 13. Impact of rising food prices on the most vulnerable



²⁷ Troskie D. Targeting Poverty: Food Gardens. Presentation to IDP workshop, Saldanha Bay, 4 March 2009

Source: Troskie, 2009

Data from the Department of Agriculture suggest that in 2009 about 17% of adults and about 13% of children went hungry in the Western Cape, with 3.5% of adults and 2.5% of children reporting being 'often' or 'always' hungry (Troskie, 2009). Wide discrepancies were noted between districts.

Figure 14. Hunger experienced by W Cape Districts, 2009

Hunger experienced:	Cape Metro		West Coast		Cape Winelands		Overberg		Eden		Central Karoo	
	Adult	Child	Adult	Child	Adult	Child	Adult	Child	Adult	Child	Adult	Child
Not at all	78.6%	75.5%	98.6%	98.7%	91.4%	92.1%	94.1%	96.7%	91.1%	92.3%	98.2%	97.5%
Seldom	4.1%	3.3%	0.3%	1.3%	3.0%	2.2%	0.9%	0.6%	1.5%	0.5%	0.8%	0.8%
Sometimes	12.7%	16.4%	0.6%	0.0%	3.1%	3.0%	4.6%	2.5%	6.9%	6.9%	1.0%	1.1%
Often	3.3%	3.5%	0.5%	0.0%	2.0%	1.9%	0.4%	0.2%	0.5%	0.2%	0.0%	0.6%
Always	1.3%	1.3%	0.0%	0.0%	0.5%	0.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

Source: Jacobs, 2009, cited in Troskie, 2009

Access to quality safe, potable water and sanitation

Access to quality water and sanitation has come up against major obstacles and continues to be a source of discontent amongst poor communities. Since 1994 government at local level has embarked on commercialisation of different functions relating to water provision. In the name of efficiency, government has used private consultants and other service providers to perform different functions ranging from water treatment and purification, infrastructure maintenance, installation of water metres, meter reading, billing, debt collection and to perform water cuts when communities fail to pay their water bills.

Because commercialisation introduces the profit motive in the equation, and because there is no coordinating centre to ensure consistency and accuracy, a number of households complain of discrepancies, inaccurate meter reading and extraordinary high amounts in monthly bills. The results are poor services delivery, discontinuation of access to water services and the accumulation of huge unpayable debts. Instead of achieving efficiency, the system has run into crises as people gets in and out of the system as a result increases in water rates and because the costs of all these functions gets transferred and built into the accounts of end –users

Affordability: Once commercialised, access to services such as water is dependent upon the ability to pay. With the current rate of unemployment at 40% (using the expanded definition that take into account people suffering long term unemployment and have given up looking for jobs) more and more people dependent on government grants, the huge increases in food prices and other essentials, and high transport costs, many people are unable to afford basic services such as water. Although government has provided free 6kl water /household per day, this is highly inadequate and does not take into account relevant demographic changes in household situations, labour migration into the cities and urbanisation.

In the attempt to deal with these problems, municipalities such as Cape Town Metro first introduced the trickle system of debt management and more recently water management devices (WMD) in poor communities. The latter devices are meant to replace the now discredited (see Judgement Supreme Court of Appeal JHB CITY Council VS Phiri (2008)) prepaid water metres albeit in new and more sophisticated forms. The Cape Town City Council sets the WMD to deliver an average of 350 litres per day or 10.62kl per month per household (which includes the free 6kl – with an additional 4.6kl is limited to "indigents"). The City Council can adjust the device for residents to receive an additional amount according to what they commit to paying.

The water management device is set to switch on at a fixed time every morning and will only switch off once the household has used its set quota of water for the day. By implication this means poor communities are using water in an irresponsible manner and to manage their water consumption and ensure their monthly water bills are affordable - basically the City Council want poor households to reduce their water usage. Moreover it is the responsibility of household to invite private plumbers should there be a need for repair work. It is clear that these measures are part of entrenching cost recovery and user must pay policy. They are also part micro monitoring of poor communities with the aim of limiting adverse effects of payment defaults on municipal revenue collection.

Acceptability: In the same way as its forerunner, the prepaid water meters, the WMDs impact negatively upon the dignity of our people. They are part of elite mechanisms of prejudice and discrimination against the social class of affected communities since the other big users of water, industry, continue to pay a flat rate per kl of water and are not subjected to WMD. Further the installation of the WMD is neither class nor gender neutral. The burden of policing other households to reduce their water usage to avoid running out of water before 5am is going to fall on women. When they fail to avoid running out of water it will be women or their young children who have to be humiliated by requesting water from neighbours or spend time walking to public institutions or churches to request water.

Access to Sanitation

For many South Africans the legacy of apartheid remains largely unresolved. The transition to democracy stabilised the political situation and created a atmosphere of a free society however socio economic conditions of the majority in urban and rural areas have hardly improved in spite of some measure of progress.

Because of desperate economic conditions of unemployment and lack of access to basic essentials people would rather be in shacks without sanitation, electricity or water just as long as they are placed closer to cities where they believe there is a likelihood to get some employment²⁸. Despite 2 million houses being built since 1994, the backlog has actually grown, now standing at 2.4 million homes.

In a place called Enkanini , which is part of Khayelitsha but straddling the Cape Flats and spread across sand dunes from Khayelitsha to Monwabisi in False bay, Cape Town, up to half a million people live in untenable conditions where there are no toilets, no roads, electricity no grass and where crime is rampant²⁹

In the Cape metro in particular, the situation is worsening as unemployment had by 2005 risen to 21% from 13% in 1997, poverty risen by to 38% in 2005 from 25% in 1996, an increased prevalence of HIV/Aids from 1.2% in 1994 to 15% 2005, and Tuberculoses gone up from 13870 cases in 1997 to 26754 in 2005³⁰. All these conditions are as a result of desperation and economic displacement where the most residual forms of social dignity have to be violated or ignored in order to survive hunger and other numerous forms of social distress.

The Western Cape has a long road to travel to align urban spatial development strategies to address the current trends in patterns of population development and the stark contrast in resource allocation between different racial groups and between rich and poor. Indications point to an increase in urban informal settlement from 12% in 2005 to 17% in 2007³¹.

²⁸ The State of the Population in the Western Cape, 2008.

²⁹ Social Housing Foundation, 2007

³⁰ The State of the Population in the Wstern Cape, 2007

³¹ Ibid

Overall up to 5.6% of households continue to use the bucket system and are without any sanitation system in the Western Cape, a province second to the Gauteng in terms of its economic indicators (14,7% contribution towards the national GDP figures in 2005 following KZN and at the top Gauteng)³²

Whilst other provinces have higher incidents of lack of sanitation there are indications that the situation in the Western Cape is improving in terms of sanitation, however there is a strange anomaly where water provision has worsened with people without water sits at 8.5% in 2004, and 30.85% in 2007³³

Cholera Breakout

During 2008, cholera broke out in a number of provinces in South Africa. The result has been that thousands of people have been infected and over fifty people died³⁴. Initially, a number of politicians tried to blame Zimbabweans - who were fleeing the economic meltdown, Mugabe's repressive regime and a cholera outbreak in their own country - for the outbreak of the disease in South Africa³⁵. Nonetheless, after several weeks the Health Department made it clear that the cholera outbreak in South Africa was not related to the one that had occurred in Zimbabwe. Rather, it was pointed out that the outbreak was linked to poor sanitation services and a lack of access to clean water³⁶. Nonetheless, the Department of Health was not willing to go any further and discuss the underlying reasons why, fifteen years after apartheid, people still don't have toilets or clean drinking water. Of course, the real reasons for this dire situation, which the Health Department is loathe to discuss, is that the government has completely failed to address the inequalities of apartheid and have rather embarked on the privatisation of water and sanitation services.

Article: www.digitaljournal.com/article/265422 - 35k (Jan 2009)

The South African health department is doing its best to censor the true extent of the cholera deaths in Limpopo province, south of Zimbabwe. The state's news outlet says the 'rumoured deaths of cholera were not scientifically confirmed in labs.'

The SA government's state-run news outlet SA Broadcasting Corporation says 'all the rumoured deaths of cholera are not scientifically confirmed because 'tests can no longer be conducted on them after they have died and are buried...'

AT least 125 new patients a day are treated at state-run cholera clinics in Limpopo province alone. And the cholera epidemic has also hit another four South African province, including three cases in the Western Cape where cholera has not ever been identified before. Two local rivers south of Zimbabwe - the Limpopo and the Tubatse - have also tested positive for cholera.

15 'mystery deaths"

Public health nurses in the town of Louis Trichardt just inside South Africa - where the latest six of fifteen deaths from 'cholera-like symptoms' have been reported yesterday - say that they are convinced all the patients died of cholera, even if the state health department can't confirm this with formal testing results. A mass funeral will be held today for fifteen people who died in the Tubatsi/Louis Trichardt municipality of Limpopo.

The experienced public-health nurses in Louis Trichardt who treat a steady stream of seriously

³² SA Institute of Race Relations

³³ Ibid, 2006,2007.

³⁴ <http://www.thetimes.co.za/News/Article.aspx?id=935049>

³⁵ www.da.org.za/?tag=zimbabwe - 32k

³⁶ www.mg.co.za/article/2009-02-02-dont-blame-zim-for-cholera

dehydrated people all day and all night long, point out that water samples from the adjacent Tubatse River used by the dead victims has tested positive for the cholera bacteria. There is no doubt, they say, that these people have died of cholera.

Limpopo's official death toll from cholera stands at nine, but overtaxed medical practitioners, nurses and other health-care workers say the South African death toll is much higher than that because communities are not being visited by the overworked health-care workers who could identify new victims. People are dying without being able to get re-hydration treatment. Cholera is a fast killer if nurses cannot get to their patients in time.

In neighbouring Zimbabwe, the United Nations has also warned that a growing number of cholera deaths are happening in rural areas beyond the reach of health workers. And scores of cholera deaths are also reported in neighbouring states such as Mozambique, Lesotho and Swaziland.

Meanwhile the United Nations reports that the cholera death toll in Zimbabwe has reached to 2,201 - and also says that the actual death rates and number of patients undoubtedly are much higher.

The United Nation's children's fund, UNICEF, has this weekend also donated \$5 million extra to help fight the cholera epidemic in Zimbabwe.

Cholera is not new in South Africa

Cholera is not a new phenomenon in South Africa. During the apartheid years there were regular outbreaks of the disease³⁷. The reason for this was that the apartheid state forced millions of people to live in appalling conditions in townships and homelands. In these areas, with very few services provided— only a few townships had clean water, most people only had shacks for shelter, very few townships had refuse removal services and only the lucky few had electricity³⁸. The outcome of this was that cholera outbreaks regularly occurred in the townships and homelands during the apartheid era. This all happened while the white population lived in very well serviced neighbourhoods with ample water for their swimming pools, regular refuse removal services that carted away the waste of their indulgent consumer culture, and subsidised electricity that fuelled one of the highest living standards in the world.

By the mid-1980s, however, communities were fighting this unjust system across the country. As a result of such pressure, some communities managed to win some gains, and certain areas even gained access to free water. Added to this, the apartheid government was also embarrassed by the international attention that some of the larger cholera outbreaks had stirred. As a consequence, they also began providing some free water in areas where the cholera outbreaks had occurred, including in a number of districts in KwaZulu-Natal³⁹.

It's the poor that have to pay

With the State after 94 giving billions to the rich, and following corporate welfare policies, it has been the poor that have suffered. Spending on social services declined in real terms throughout the 1st decade of our democracy. Indeed, funding for local governments - who are largely responsible for providing clean water, housing and sanitation - declined by 85% between 1991 and 1997⁴⁰. This means that the budgets that existed, and exist, for services are grossly inadequate. For example, the Department of Housing stated that the total budget for housing

³⁷ www.queensu.ca/msp/pages/In_The_News/2003/Feb/4.htm

³⁸ www.queensu.ca/msp/pages/Project_Publications/News/flush.htm

³⁹ Hemson, D., Dube, B., Mbele, T., Nnadozie, R. % Ngcobo, D. 2006. *Still Paying the Price: Revisiting the Cholera Epidemic of 200-2001 in South Africa*. Municipal Services Project: South Africa

⁴⁰ McDonald, D. & Smith, L. 2002. *Privatising Cape Town: Service Delivery and Policy Reforms Since 1996*. Municipal Services Project: South Africa.

across South Africa was R 10 billion in 2008, yet by their own admission it would cost at least R 258 billion to address the housing backlog that already existed⁴¹. With such small budgets for social services, millions of people still don't have access to clean water, housing, refuse removal and sanitation, and will probably never receive these services in their lifetime. This means people's living conditions remain poor. It is in this context that peoples' health has been negatively affected and outbreaks of cholera occurred.

Due to the government's commitment to fiscal austerity, and policy of giving money to the rich, the state has completely failed to address the inequalities of apartheid. This means that former white areas still receive far more resources for clean water, refuse removal, and sanitation than townships. For instance, the elite suburb of Durbanville in Cape Town, which has a population of 35 000, receives 4 times more money per person for waste removal than the township of Khayelitsha, which has a population of 450 000. With regards to water services, 8 times more money is spent per person on providing water to Durbanville residents when compared to Khayelitsha⁴². Similarly, in Johannesburg, almost 30% of all residents still live in shacks, while 52% of people still have inadequate sanitation services. This occurs in a context where rich suburbs, such as Sandton, have one of the highest rates of water consumption in the world⁴³. As if this was not awful enough, the state also passed a national law to prevent any form of progressive cross-subsidisations of services⁴⁴. In conjunction to this, the state adopted a full cost recovery policy for public and social services. As a result, people who can't afford to pay have their services cut – which also means historical inequalities are simply not being addressed. Consequently, millions of people in the townships are still being forced to live in an environment where outbreaks of cholera and diarrhoea occur.

Privatising Water services

The government has also promoted the privatisation and commercialisation of public services through GEAR and the Municipal Infrastructure and Investment Unit⁴⁵. This has seen clean water being sold as a product. The result has been that over 10 million people, who could not afford to pay for water, had their access cut.⁴⁶ Clearly, the government has chosen profit over the people, and has even implemented policies that solely benefit multinationals.

In Johannesburg, for example, the City's water services were outsourced to Suez⁴⁷. Suez began selling water as if it was just another commodity and made massive profits out of this. This arrangement, however, caused massive problems for the poor, many of whom were cut-off because they could not afford to buy water from Suez. Indeed, at one point as many as 20 000 households per month were having their water cut⁴⁸. The result was that many of these people had to find other sources of water, such as nearby rivers. In places such as Alexandra, this caused outbreaks of cholera and diarrhoea when people were forced to use the heavily polluted Jukskei River in order to get water to drink and clean⁴⁹. When people protested, however, they were shot at by the police and in some cases forcefully evicted from their houses.

In 2000 and 2001, there were also massive outbreaks of cholera in KwaZulu-Natal, the Eastern Cape and Mpumalanga. In some areas of KwaZulu-Natal, people had been receiving free clean water since the late 1980s. By the mid-1990s, however, the government had outsourced the running of these services to the multinational Biwater. Biwater, in order to make profits, started to charge people in KwaZulu-Natal for water. Most people could not afford to pay the prices

⁴¹ [www.search.gov.za/info/previewDocument.jsp?dk...htm%40Gov&q=\(...\)+%3CAND%3E](http://www.search.gov.za/info/previewDocument.jsp?dk...htm%40Gov&q=(...)+%3CAND%3E)

⁴² McDonald, D. & Smith, L. 2002. *Privatising Cape Town: Service Delivery and Policy Reforms Since 1996*. Municipal Services Project: South Africa

⁴³ www.sarprn.org.za/documents/d0000584/index.php

⁴⁴ www.info.gov.za/gazette/acts/2000/a32-00.pdf

⁴⁵ www.transformation.ukzn.ac.za/index.php?option=com_content&task=view&id=282&Itemid=6

⁴⁶ www.apf.org.za/

⁴⁷ McDonald, D. & Smith, L. 2002. *Privatising Cape Town: Service Delivery and Policy Reforms Since 1996*. Municipal Services Project: South Africa.

⁴⁸ www.sarprn.org.za/documents/d0000584/index.php

⁴⁹ www.hst.org.za/news/20010405

Biwater was charging and had their water cut. These people were forced to use polluted streams and springs to try and get water. The result was that cholera broke out, with the consequence that 117 000 people were eventually infected and 265 people died⁵⁰. Again, the government showed little compassion for the people even though privatisation was literally killing them.

In Cape Town, water, sewerage, and refuse removal services have also been outsourced or commercialised. In fact, the City used funds from USAID to hire a private company, Price Waterhouse Coopers, to assist in the formulation of its social services policies, which explicitly promoted public-private partnerships and cost recovery. As is always the case, it was the poor who have suffered the consequences. Hundreds of thousands of people have had their water cut off because they can't afford the high prices that the City charges. In 2000 alone, 377 000 township residents had their water cut in the Greater Cape Town area⁵¹. The result was that people were forced to re-use dirty water for cleaning and drinking.

After various community struggles around 2000, a small free lifeline of water was gradually rolled out to areas that consisted of formal houses, and that had the necessary water infrastructure. However, this lifeline was completely inadequate, with the result that people re-used their quota of water over and over, which had negative health implications. Added to this, most informal settlements never received the lifeline due to a total lack of infrastructure. Recently, this led to an outbreak of cholera in Cape Town⁵². The City of Cape Town, however, has not budged. In fact, it has embarked on a major campaign to install water management devices in indebted households across Cape Town. These devices allow for 350 litres of 'lifeline' water a day. However, once this is finished the water supply cuts off automatically. Considering that most people live in large households, 350 litres a day is totally inadequate⁵³. People have begun using buckets to store this water, and again are being forced to re-use this water over and over. The problem is that reusing water has already caused outbreaks of diarrhoea. It seems almost inevitable that the water management devices, which are forcing people to re-use water, are going to cause more outbreaks of cholera in Cape Town.

Cholera outbreaks still occur in South Africa because the state has failed to address the inequalities of apartheid. In fact, both national and local governments in South Africa have promoted the idea that water should be sold as a commodity. This has meant that millions of people, even when the infrastructure exists, don't have access to clean water because they can't afford the high prices charged for it. This is a major issue, considering that over 40% of South African's are unemployed and simply don't have the money to pay for clean water. Unfortunately, there is little hope that this will change in the future, or that free water for all will be rolled out across the country. All of the parties involved in the last election, including the ANC⁵⁴, COPE⁵⁵ and the DA⁵⁶, remain committed to neo-liberalism and the commercialisation of services. This means that all of the major political players remain committed to selling water as a commodity, and will continue cutting people's water if they don't pay for it. This, in turn is going to force people to re-use the water they do manage to get, or access water from other sources such as streams. Consequently, cholera is set to occur again and again in South Africa. The only way this will change is if people organise themselves and win free water for all through their own actions. Indeed, if cholera outbreaks are to be stopped then all people need to be given free clean water and sanitation – not inadequate lifelines. The truth is that water is essential for life, and it should not be viewed as a product to be bought and sold.

⁵⁰ Hemson, D., Dube, B., Mbele, T., Nnadozie, R. & Ngcobo, D. 2006. *Still Paying the Price: Revisiting the Cholera Epidemic of 2000-2001 in South Africa*. Municipal Services Project: South Africa

⁵¹ McDonald, D. & Smith, L. 2002. *Privatising Cape Town: Service Delivery and Policy Reforms Since 1996*. Municipal Services Project: South Africa

⁵² www.iol.co.za/index.php_set_id=1&click_id=13&art_id=vn20081218060422896C734726?

⁵³ Xali, M. 2008. Water Management Devices: A Cost Recovery Tool Targeting Poor Communities. Unpublished Paper presented at the Water Caucus.

⁵⁴ www.polity.org.za/article.php?a_id=148700

⁵⁵ www.copempu.co.za/blog/2008/12/21/draft-policy-document/

⁵⁶ www.da.org.za/?p=1480

Access to Social Security

As outlined in the SAHRC submission on national social security by Black Sash and a range of civil society organizations⁵⁷, poverty is an internationally contested issue and the way a country defines the concept of poverty depends largely on the commitment of societies to address the causes and effects thereof. In addition, poverty is multifaceted, reflecting unmet needs and exclusions across complex and often mutually reinforcing dimensions.

However, the national submission argues that what no-one can deny is that poverty in South Africa has reached crisis proportions. The triangulation between poverty, unemployment and inequality is seldom as starkly visible in other countries, and the reach of apartheid racist policies continues to be reproduced within these domains, despite the South African constitutional guarantees of the right to life, to dignity and equality, and the guarantees of the justiciable socio-economic rights contained in Chapter Two of the South African Constitution. The scale of the problem sometimes seems to paralyze the search for solutions and relief programmes.

A headcount analysis of people living in poverty (below a poverty line) depends of course on where that line is drawn, and the data source used. South Africa has no official definition of poverty, nor any official measurements of poverty. It has been set at about 43% in 2006 using conservative data. The 2009 national submission argues that South Africa is not meeting its MDG to eradicate poverty and hunger because it has not fully embraced the mechanisms outlined in the Constitution, specifically social security. This is despite the fact that it has been shown that a comprehensive system of social security is one of the most successful and efficient ways of making a qualitative difference to the lives of impoverished people.

Impact of social grants on poverty and inequality in the Western Cape

Since 1994, social grants have been deracialised and extended to a much greater number of people (although it must be noted that pensions were equalised in terms of race in 1993 already). We recognize that this was a significant achievement considering the reorganization of state bureaucracy and administrative challenges faced by the young democratic state.

Now, over 12 million people receive social assistance nationally. The beneficiaries are largely comprised of about 8 million children who receive the Child Support Grant (CSG), however, the CSG is the lowest value of all grants. The cost of the social assistance programme has increased nationally and is at a modest level of 3, 5% of GDP. The total percentage of people living below the poverty line appears to be dropping since 1997. This trend has been ascribed to the large increase in the availability of social grants, particularly since 2000. This suggests that the apparent decrease in poverty is not a structural decrease, but reflects that people are better off on a monthly basis as a result of receiving a social grant.

The income of social grants into poor households has been found by Statistics South Africa to lower the Gini coefficient in terms of income inequality from 0.80 to 0.73, which is significant. This is a powerful argument in favour of extending coverage to social grants to currently excluded poor people should the state be concerned at the apparent unstoppable increase in income inequality within South Africa.

Meaningful Participation

⁵⁷ Social Security in South Africa, 2009 submitted to SAHRC by Black Sash, Community Agency for Social Change, National Welfare Forum, South African Council of Churches, Studies in Poverty and Inequality

A number of sources make the issue of participation central to the content of the Right to Health. Firstly, the Alma Ata Declaration on Primary Health Care argues that “people have the right and duty to participate individually and collectively in the planning and implementation of their health care” (Clause IV). This is echoed in the General Comment 14 which indicates that the right to health also includes “participation of the population in all health-related decision-making at the community, national and international levels” (paragraph 11). Our national policy documents reinforce this by emphasizing the role of people’s “active participation and involvement” as essential to making progress in improving health status and framing “community participation across the health sector” as a key objective of a Transformed Health Service that will “involve communities in various aspects of the planning and provision of health services” and “establish mechanisms to improve public accountability and promote dialogue and feedback between the public and health providers.”⁵⁸ (Ministry of Health, 1997)

In order to meet this policy objective, the National Health Act (Paragraphs 21..2(h) and 25.2(t)) places obligations on national and provincial department heads to “promote community participation in the planning, provision and evaluation of health services” and provides for the establishment of Clinics and community health centre committees (Paragraph 42) and Hospital Boards (paragraphs 41.4 to 41.8) but leaves the details to provincial regulations or Ministerial prescription.

Clinic Committees

Clinic Committees have been in existence in the Western Cape for over 18 years, long predating the current legislative arrangements.

Currently in the Western Cape 76 Clinic Committees exist and are coordinated at sub-district, district, local and at Metro level by the Metropolitan Community Health Forum (MCHF).

The MCHF is active in both civil society activities in relation to health rights as well coordinating relationships between the state at provincial and local level and Clinic Committees (CC’s) activities in the communities they are active in. These community structures are run by voluntary workers and their mandate of coordinating participation in health or health related activities is supposed to feed into health processes on the ground; intervene in combination with either provincial or local authorities when violations occur, and work with other community structures, NGOs or CBOs active in health within their communities according to the NHA

The CC have had a modest number of successes in a range of areas for example, in many cases CCS have acted as a vehicle for communities voices to be heard when violations occur and in some cases established positive relations with the state at both local and sub-district level impacting positively on service delivery.

However, the extent of CC activities and their participation in health matters have been uneven over the years. Most CC functioning is weak or in some areas non-existent due to the following challenges:

No clear provincial policy guidelines

A provincial policy framework was tabled in 2005 with the aim to formalise the MCHF and ensure sustainable community participation in healthcare service delivery on the ground. However to date this document has not been signed off by the MEC for Health in the province.

The National Health Act obligates provincial government to host a consultative forum on an annual basis, to ensure community participation. However, since 2006 the DoH has not hosted a provincial consultative forum within the Western Cape. After repeated requests over the years,

⁵⁸ White Paper For The Transformation Of The Health System In South Africa. Ministry of Health, Pretoria, 1997.

during April 2009 a provincial health conference was initiated by the MCHF which was partly funded by the DoH to the value of R55 000 yet the requested assistance and support totalled approximately R700 000⁵⁹. At the date of submitting this submission the DoH had still not released all the funds.

Limited Resource Allocation at Metro Level:

Since 2004 the Provincial Department of health has provided resources for the following activities:

Coordination at Metropolitan Level: R15 000 per sub-district is provided per annum to ensure that members of CCs can attend MCHF plenary meetings and capacity building activities. The R15000 covers travelling, catering and administrative costs of approximately 10 people per CC x 76 CCs per annum to coordinate activities.

Capacity building activities organised by the provincial DoH for the period 2006 – 2009 include: public speaking, minute taking, proposal writing and petty cash to mention a few. Some of the benefits of the training were the following: For newly established committees participating in a workshop where they could share ideas and lessons with one another was useful as this enabled them to establish their own committees and deal with violations but not necessarily ensure meaningful participation within their communities. However, none of the CCs at community level manage their own budgets as petty cash is handled at sub-district levels, yet all committees were offered petty cash training. Furthermore the CCs are not allowed to fundraise, yet they went on a proposal writing course

Raising awareness around the role of CCs: In 2006 provincial government funded the Face the People Exhibition which told the stories of Clinic Committee members across the 8 sub-districts. This was a useful exercise to ensure that people were aware that they could complain via the CCs, however this was a once off campaign

No Resource Allocation at Local Level:

Though legislated, CCs do not receive funding for day to day running costs at local level and cover their own daily administration and operational expenses. Ensuring violations are reported at local level and monitoring service delivery at the clinics they are associated with as prescribed in the Annual Performance Plan of the DoH is done on a voluntary basis with no infrastructural or institutional support at the clinics where violations occur.

At both MCHF and CC levels representatives are predominantly unemployed, functionally literate individuals performing voluntary work, resourced from their own pockets (other than travel, catering and administrative costs in relation to capacity building and meetings at Metro level). They receive no stipend or compensation for this work which is in contrast to other similar participative structures, for example the Multi-Sectoral Action Teams (MSATS) who are coordinated by the City of Cape Town, receive salaries, and are eligible for learnerships enabling them to receive recognised qualifications, skills and experiences.

Other issues impacting on service delivery:

- MSATs and CCs both operate in the same communities, often duplication of services result due to lack of coordination between local and provincial government creating tension between the MSATs and the CCs on the ground, which waste resources as well as impact negatively on service delivery
- CC representatives lack the understanding of what their roles are as community structures and view their main function as reporting violations. However when complaints are made, they are not involved in actions to follow up on complaints.

⁵⁹ MCHF Proposal and Concept Document to PGWC DoH, April 2009

- CC representatives have minimal access to facility managers, patients complaints or community structures due to lack of resources. Furthermore the DoH does not involve the CCs or other community participation structures in developing its Annual Performance Plans (APPs), until the penultimate draft of the APP comes before the Provincial legislature. Nor does the DoH report back to the MHCf on progress on its APP indicators.

Access to education and the promotion of health rights

In Chapter 2 of the Constitution of the Republic of South Africa - the Bill of Rights - a number of social, administrative and other rights are set out in addition to the rights of freedom, human dignity, property, labour, political, cultural, religious and citizenship rights. These social rights include rights in respect of education, housing, healthcare, food, water and so on.

It would be entirely consistent with the spirit of the Constitution to assume that these social rights imply a direct responsibility on the democratic state. This would be especially so because these social rights relate to areas of public interest such as health, education, housing, etc and it could hardly be countenanced that either the private citizenry or some other interest would be able to deliver these rights.

Section 7(2) of our Constitution in line with international human rights law, imposes the following duties on the state: the duty to respect protects, promote and fulfil the rights. The state would therefore be expected (within the framework of the limitations set out in the Constitution) to give concrete expression to its Constitutional obligations and any attempt by the democratic state to abdicate its responsibility in this regard would be a breach of a fundamental covenant of the law.

Moreover, such a responsibility cannot be taken lightly, especially in the light of the specific injunction requiring that any limitation be 'reasonable and just based on human dignity, equality and freedom...' The express meaning of this provision would, for instance, not be consistent with the increase of inequality and the loss of human dignity by the poorest sections of our society for whom the Constitution chose to speak. It is also true that these social rights may be limited because of considerations of practicality - such as the absence of financial resources. But here too, the spirit of the constitution is a clear *imprimatur* on the state. Such practical considerations must be weighed against the questions of justice, reasonableness, human dignity and inequality. This would mean, for instance, that in the context of resource constraint, redistributive measures could (should) be invoked to ensure that the effects of the 'practical' constraints do not increase inequality. It means that the state is obliged to find solutions which specifically do not impose the greatest hardship on those most disadvantaged in our society.

Section 29 of the 1996 Bill of Rights gives everyone the right to a basic education, including basic adult education. In addition, everyone has the right to 'further education', which the state must 'make progressively available and accessible.' Internationally, the right to education has been recognised as a precondition for the enjoyment of many civil and political rights, such as freedom of information, expression, assembly and association, the right to vote and to be elected or the right of equal access to public service depends on at least a minimum level of education, including literacy.

Numerous international conventions and (Convention on the Rights of the Child, UNESCO's Convention against Discrimination in Education, the International Covenant on Economic, Social and Cultural Rights (ICESCR) besides emphasising the duties of the state add the following obligations of result:

- a) Primary education shall be free and compulsory for all;
- b) Secondary education shall be available and accessible to all; in addition free education and financial assistance in case of need shall be introduced;

- c) Higher Education shall be accessible to all on the basis of capacity; and free education progressively introduced;
- d) Fundamental (basic) education shall be intensified for those not having completed
- e) primary education;
- f) Programmes of special education should be established for the handicapped; and the elimination of illiteracy.

While many countries refer to lack of financial resources to justify that primary education is not free, article 13(2)(a) of ICESCR is framed in mandatory, explicit terms, leaving the state no escape (Coomans/Hoof, 1995). When discussing, for example, the report of Zaire, the UN Committee on Economic, Social and Cultural Rights made it clear that charging fees for primary education is contrary to Article 13(2)(a). A state party cannot justify such a measure by referring to severe economic circumstances: 'The provision of such education is an obligation which remained incumbent upon a state party whatever economic system it had adopted' (Coomans/Hoof, 1995).

Thus, the government assumes human rights obligations directly relating to education and specific to the South African Constitution to promote human rights. As a component of health, access to and promotion of health rights information is the basic minimum a state should provide. These two issues therefore have to be critically explored in terms of how the state's obligations are being defined and discharged, and existing mechanisms to hold the state accountable for education and promotion of human rights obligations within the province.

Furthermore, particular to the South African Constitution is the obligation to promote human rights further obligating the state to ensure not only general education but education in relation to human rights.

Implications of low literacy levels

The legacy of illiteracy, lack of numeracy and lack of high-level skills in the mass of the population in the Western Cape has been one of the highest costs of apartheid. Aitcheson (2006) based on his report to the National Ministry (2008) reexamines the mid to late 1990s consensus on South Africa's illiteracy statistics (based largely on Household surveys and the 1996 Census data) which formed the baseline starting point for various government adult education provision and campaign goals (such as Education for All and the South African National Literacy Initiative), and finds that the actual number of illiterates has not been significantly reduced (if indeed they have been reduced)⁶⁰

Illiteracy as a barrier to access to health:

Illiteracy impacts on all aspects of life - power and performance in the labour market, but also in the home and community. An informed citizenry who are educated about their health rights, roles and responsibilities are able to assist and support individual and community access to health and healthcare through engagement and building of health rights within communities. Moreover, the simple expectation that health service users will understand written communication regarding their treatment or their next appointment may be an assumption that is not realistic, more so because of power relations between provider and patient that leave the patients feeling far too intimidated to admit to not understanding basic instructions. As a result, both access to health care for the patients as well as the efficacy (and cost-effectiveness) of health care intervention is significantly compromised by the ongoing persistence of illiteracy in South Africa.

Promoting and building human rights understandings do not feature particularly strongly in state provisions and human rights information reaches the fortunate few who know such information exists. Not only do people have to struggle to access services, but struggle to access

⁶⁰ Aitcheson report to Ministerial Task Team (2006) <http://www.unp.ac.za/cae/caehighlights.htm> - 27k

information about these services. For example The Batho Pele Principles which serve to govern service delivery of the public sector (General Notice 1459. Government Gazette 18340, 1997) often do not exist even in poster form in some public healthcare institutions. (Thomas, 2007)). Even where they are mounted, most people who attend public institutions have low level functional literacy skills and often are unable to interpret the content of the poster.

The Patients Rights Charter, since 1999 offers guidelines on patients (and healthcare providers) rights and responsibilities and sets the standards of healthcare which provides a framework for patients' rights. The majority of people who attend public healthcare facilities are not aware of the Charter though it should be displayed in all public healthcare facilities⁶¹.

At most healthcare institutions complaints boxes are located, however people feel that these complaints mechanisms don't work⁶² (Thomas, 2007). Even if people do understand these frameworks, the culture of institutions prevent them from drawing on these principles as complaints and other institutional mechanisms to enforce them do not work.

Holtman et al. (2004), in their research study around the Patients' Rights Charter, and Thomas (2007) in her study around health rights argue that this is because healthcare practitioners have been viewed as holders of knowledge and play a powerful role in either facilitating or denying access to healthcare. Both studies found that when they interviewed patients about difficulties experienced within the public healthcare context, many respondents tended to report issues such as a lack of assistance, aloofness, hostility, lack of communication and the lack of supportive relationships between public healthcare professionals and patients. Secondly both studies insist that education programmes need to be developed because international and regional treaties, national constitutional provisions and legislative frameworks have little value if the people they were created to protect don't know about them. However, relevant education to ensure understanding of health rights is largely left to non-governmental organisations and community based organisations. Importantly, the South African Constitution differs from other constitutions in that it obligates the state to **promote** health rights as well as provide access to information, providing scope to challenge the state to ensure education and information around health rights. Within such circumstances, educating people to advance their health rights should be of the utmost importance and it is precisely this relationship which this submission advocates the Commission to explore with the state.

The evidence in these studies are recently supported by the section of children's rights in this submission as well as the article on the cover page. Instead of improving access to health and healthcare in the province appear to be retrogressing rather than progressing.

⁶¹ Thomas and London (2006)

⁶² Thomas, J (2007) Is knowing you have rights enough (Masters Thesis)

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Section 5: Key Questions and Recommendations



Below we have tried to link some of the evidence to some key questions and recommendations as examples of ways in which the SAHRC may interrogate government's submissions to this call.

Outsourcing of healthcare services

Key Questions:

The Commission should ask the state:

- To what extent has government shifted responsibilities for core functions to CBC workers what used to be the responsibility of full time professionals within the health services?
- Have such responsibilities been shifted with adequate support and resourcing?
- Has government considered the discontinuation of the comprehensive model of CHW provision and its replacement by Home-based carers and Community-based carers as a potential form of retrogression that is not permitted under the ICESCR?
- Does government believe the current form of community based care to be advancing access to health care as it is defined in the General Comment 14?

Recommendations:

- Government should work harder to operate in an intersectoral manner rather than have similar programmes fragmented across different departments. NGOs and CBOs should not have to deal with multiple government departments insisting on control of programmes that from a Primary Health Care perspective should hang together.
- Government should adequately fund overhead and support costs to NGOs with CBC worker to ensure a good quality service, rather than expanding quantity of carers appointed.
- Establishment of functioning District Health Management systems should help to address some of the obstacles identified in the past

- Efficiency of financial management and payment systems should be a priority of government – it is not fair to expect CBOs and NGO's to bear the brunt of cash flow difficulties arising from inefficiencies within government.

Access to safe potable water and adequate sanitation

Key Questions:

The Commission may wish to ask the state:

- About the impact of the commodification and cost recovery mechanisms in the provision of basic services.
- For more information on how they have closed the long-standing inequalities around access to safe potable water and adequate sanitation between rural, urban, rural and peri-urban areas.
- About increasing, in the short term, the current 6kl /household of free water per month which has been proven to be inadequate and over the years been overtaken by population increases and migration from rural to urban centres.
- Are access to adequate health care and other protections inclusive and cover individuals and groups not considered to be official citizens of SA and the province such as refugees, asylum seekers and displaced peoples? Is the principle of indivisibility of justice applied in the provision of health care?
- Investigate the use of water management devices (WMD) by government in the Western Cape and to establish whether these comply with the requirements for access to adequate supply of quality water services as outlined in international frameworks.

Recommendations:

- Reversal of the commodification of basic services including water provision.
- Scrapping of all current cost recovery mechanisms such as water metres and or water management devices in the townships, squatter camps/informal settlements as these measures stand between poor and indigent communities and their rights to the provision of adequate water and sanitation.
- Institute a payment system underpinned by the principle of cross-subsidisation and not one which targets and discriminate against the poor and the indigent.
- Review with the purpose of expanding the current definition of 'indigent' "in line with current trends of deepening poverty and distress due to economic crises, unemployment and the proliferation of ecological disasters.

Access to Social Security

Recommendations

- The state must provide a clear road map that demonstrates how the right to social security within a genuinely reasonable framework will be realised as guaranteed in our Constitution.

- Developmental comprehensive social protection must be rolled out in such a way that it acknowledges that poverty has many dimensions beyond income, and entitles recipients to a basket of psychosocial and economic benefits to enable the realisation of the spectrum of human dignity.
- Monitoring of implementation. We call for the activation of the Social Development Advisory Board as a multi-stakeholder body to oversee the roll out of a comprehensive social security system.
- We call on the South African Human Rights Commission to have an urgent investigation into poverty in South Africa.
- We suggest a standing commission on poverty that considers and defines the multi-dimensional nature of poverty and, goes further to establish a baseline or poverty matrix. This inquiry should also engage with the progress of a roadmap for the progressive realisation of the right to social security (with the advisory board). Therefore, it will include a commission on comprehensive social security in South Africa.

Ensuring meaningful public participation

Access to education and promotion of health rights

Key Questions:

The Commission should ask the state:

- To what extent is the state putting into practice its obligation to **promote** the right to health? What measures have been implemented to ensure that communities are better equipped to assert their rights in health and to what extent have they been evaluated for effectiveness?
- What steps have been taken to improve the effectiveness of such measures?
- What indicators does the department use to track progress in enhancing patient awareness of their rights and of departmental policies such as the Patients' Rights Charter and Batho Pele?
- Are communities able to interpret policy and the effects it will have on their daily lives? What are the state's indicators?

Recommendations:

- Invest in human rights education programmes which go beyond poster campaigns and promote understanding, dignity and respect for human rights. Civil Society has always contributed to human rights education. A number NGO's and CBO's are available who can assist with good practice examples, which could be extended in and across communities with additional government resources enabling both communities and institutions to engage in a structured manner and creating opportunities to access healthcare at local level.
- Every user of public healthcare and other state facilities should be informed of their rights. Greater provision should be made for those who are isolated such as the rural poor and people with disabilities, to ensure that education is accessible to all.

- Children and young people should be encouraged to actively participate in civil society as a way of promoting human rights and citizenship.
- Anti-discrimination policies and programmes which encourage equity, accessibility, respect, dignity, tolerance and diversity should be further promoted in non-formal and formal programmes across government departments
- The state should include awareness of rights in their Annual Performance Plans and include local community structures should be actively involved in raising awareness

Clinic Committees

Key Questions:

The Commission may wish to ask the Provincial Government:

- To what extent is the state putting into practice its obligation to **promote** the right to health through community participation structures such as the CCs?
- Why has the Provincial Policy Framework not been signed off? What is the status and the process of recognition of CCs as key structures to ensure effective functioning and efficient use of public resources needed for good health?
- How able are CCs to interpret policies and budgets which impact on their communities health? How does the state assess this
- What steps have been taken to ensure adequate resources are available to support CCs at local level?
- What indicators does the department use to track progress in enhancing the activities of CCs to ensure patient awareness of their rights and of departmental policies such as the Patients' Rights Charter and Batho Pele?
- Is government able to provide periodic results of their assessment, monitoring and evaluation of policies and programmes to determine the progressive realising of socio-economic rights on the ground? Does it make such information publicly available? Does it specifically solicit comment from its community participation structures on its progress or lack of progress with regards to its APP indicators?
- The state should Invite Communities and community clinic committees to participate in APP processes from the start. This areas of work should be part of a Senior Health Official's responsibility to that key policy engagements are attended by community structures, as well as s/he attending community participation meetings
- Complaints mechanisms should be rendered more effective - the state should ensure clinic committees are present when complaints boxes are opened.
- A communication line for complaints and a civil society health ombudsman should be investigated to ensure greater accountability within health and healthcare
- Ask the government to put in place timely procedures to consult with civil society groups in all districts and sub-districts of the province in advance of compiling their periodic report to the SAHRC, their APPs and reports on the MDGs

Conclusions

In conclusion we would like to make the following recommendations to the SAHRC

- request that government supply concrete information and results of their assessment of progressive realisation of these rights under each of the articles contained in the Covenant.
- what are government's criteria in measuring progressive realisation of rights to health under the Covenant? How does it reconcile cutbacks in certain services with retrogression in terms of people's rights of access to health care?
- Interrogate government's submissions to this call as would be the case in a Shadow Report approach.
SAHRC could make it a lot easier for community organisations by:
 - a) Having a second deadline for CSOs to comment on what government has submitted, so that CSO's can see what govt claims
 - b) Setting up community consultations in all major centres including rural areas outlining how such shadow reports can be done.
 - c) Providing a template for shadow reports
 - d) Providing outreach staff who will assist Community-based CSOs to submit shadow reports.
- Interrogate the effectiveness of the SAHRC process since the last hearings and how the Commission has monitored its own performance
- It remains a matter of grave concern that the South African Government continues to ignore the International Covenant on Economic, Social and Cultural Rights (ICESECR). South Africa has signed but as yet not ratified the treaty, despite numerous calls from civil society for it to do so. The rights contained in the Covenant conform largely to those contained in the Constitution which makes the state's failure to ratify the Covenant all the more baffling.

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Section 6: Qualitative Data



Cases collected during 2008

These case studies were collected from a group of civil society organisations and their constituencies during August 2008.

Case 1: Access to contraception

One of the women went to the local clinic to obtain contraceptive pills. The sister at the clinic blurted out what type of medication she wanted in front of everyone in the waiting room and asked her why she wanted to take the pills. What was implied was that she wanted to have sex without having children. This judgement severely impacted her access of the reproductive health care services that were offered at the clinic. This woman was so humiliated that she decided to go to the pharmacy to get the pills herself. The woman felt that her right to dignity, bodily integrity, acceptable health care and confidentiality was violated. It was agreed that the situation occurred because the sister used her power, her position and her educational status to talk down to someone who she felt was not informed. This also occurred because the women involved did not feel she had the courage or support to stand-up against the system. The situation is ongoing since nothing has changed. What the woman feels needs to happen is that the system must change since she is but one case amongst many.

Action that could be taken to redress the situation is the implementation of a complaints mechanisms or a support body. If more people have information on their right to health, what they can do and a support body behind them, then it is likely that cases will lead to action. If a suggestion box is installed and the health committees are present when the complaints are read, then the committee can work with the facility to address the complaints. Also, if there is a support structure that is community-based where people can take his/her issues, then people are more likely to take-up the human rights violations.

Case 2. HIV discrimination at a health care facility

Place X support group: They worked to advocate against the use of two doors at the clinic- one for HIV/AIDS patients and another for 'regular' patients. This infringed on the HIV/AIDS patient's right to confidentiality since their status was disclosed merely by their use of the service. In addition, it interfered with their use of the health service.

This group mentioned above offers support to HIV/AIDS patients and helps redress the rights of these individuals. This means that the people not only know of their rights but can operationalize their rights with support of the organisation. Today, any patient coming to the clinic can use either door.

Case 3: Missed appointment leads to denial of care

“I went to the clinic with my child but not on the day that I had an appointment- I went a day later. But the sister at the clinic said that she was not helping me because I was late and I must go to the back of the queue; she said it was her decision. So I said no, it is not only your decision; I also have a decision in this. But then the other nurse came to me and said, “No, it is sister's decision. The sister is actually doing you a favour by seeing you because you don't have an appointment today.”

But this really angered me because I know I have a right of access to health care. Then the sister and I had it out- we went to her office and had a whole argument. But after a long story we finally got to a place where we could negotiate and a way to deal with the situation. The nurse said that she understands my situation and that they will help me because I held that there was no reason to move me to the back of the queue.

But the nurse also said that I need to understand that if I'm going to miss my appointment I must call the clinic to let them know. But I felt there are no numbers up so why should I phone? Anyways, after all this I got helped but we could move quicker if we had a more adversarial approach and if we immediately started to talk to each other with dignity and respect.”

Case 4: Patient not admitted to maternity unit

Mr. X's wife was pregnant and ready to deliver their baby. Mr. and Mrs. X lived far from the Maternity Obstetric Unit so Mr. X had arranged to hire a car to take his wife to the Health Centre when she went into labour. They arrived at the Maternity Obstetric Unit but were told to go away and come back later, since Mrs. X was not ready to deliver. He was not told why she could not be admitted and Mr. X did not understand why they were sent back. They went home, only to return to the Maternity Obstetric Unit later that day because his wife's labour progressed. But, for the second time, Mr. X was told that his wife was not ready that they should return home until she was ready. Again, Mr. X did not understand why they were being sent away. He believed his wife was about to give birth but he was not given any further information.

On their way back home, Mrs. X's water broke and Mr. X was forced to call an ambulance. Mrs. X delivered her baby in the back of the ambulance, and the baby was wrapped in silver paper to keep the baby warm. When they finally reached the Maternity Obstetric Unit where she should have been admitted, it was raining, and in transferring the patients (Mrs X and her newborn), Mr X saw the silver paper fall off his baby.

He felt that it was an embarrassment for his wife to give birth in the back of an ambulance and an injustice to his baby who was wrapped in silver paper rather than in blankets as would have happened had his wife been admitted to the maternity unit at an earlier visit.

Mr.X's rights were violated. These cases are ongoing as they take place in several places all the time. The clinic staff violated the rights of Mr and Mrs X and their baby by not giving any information. The effect of the rights violation was an infringement of their right to health. Perhaps this right was violated due to a shortage of staff and beds or lack of capacity due to improper training. In an effort to redress this violation, Mr.X wrote a letter but he did not get a response. There was the potential to get a better outcome if Mr and Mrs X were given more information regarding why they were turned away the first few times.

Case 5: Home based carers and the mentally ill

A female neighbour came to the house naked, making a scene and swearing in front of the family (children included). Two weeks earlier, the neighbour had a child who was killed by a car so the neighbour was making claims that the woman involved had conducted witch craft to make the child die.

The woman who was sworn at went to the police station to report the incident. The police told her that the neighbour was unwell and nothing was done. The woman felt that the law was

favouring the unwell but her and her family's rights were violated. The children were traumatized after the incident and their right to a healthy environment was violated.

This situation likely occurred since there was no support for the woman who was unwell (family, social services, etc.). If her extended family was educated on her condition, then they might have been there to help and ensure that she adhered to her medication.

There are many home-based carers in the community that come across similar situations with the mentally ill. The home-based carers do not have enough support to deal with these situations, nor do they have adequate information or knowledge to deal with mentally ill patients. Yet they are currently expected to decide when those who are mentally ill should be institutionalized. There is a severe lack of support and resources for the home-based carers who are often traumatized by these situations but are not sure what action to take.

Case 6: A father violates a child's right to health

Area of case study: An informal settlement just outside of a rural area. This is a large settlement with a number of resources such as a clinic, schools, police station and a few NGO's within the area. General financial level is low. Unemployment is high.

Client: Old father and young son of ten years. Mother passed away when child was very young.

Support system: Non identified

Poverty level: Father is a worker on a farm several kilometres away from their residence. The family reside in an informal structure. They struggle financially.

Grant: Child not in receipt of a child dependency grant

Context: The rural Social worker was contacted by a farm manager in Place Y. The farm manager expressed concern over one of his workers whose son has epilepsy. The farm manager was concerned as the father had often stated that his son was not well and not able to be left alone as his seizures were not under control. The father had stated that there was no one to care for his son whilst he was working on the farm. The father needed assistance as how to address his problem. The Social worker made an appointment to see the farm worker and manager to discuss the case and gather further information about the child's condition.

Content: Upon meeting the father the following became evident:

The father was not able to give a thorough description of the child's developmental a chronological order.

The father had a complete lack of understanding about his son's condition. This was evident in the way he described his son seizures. He called them "strokes" and when asked when the seizures had started he gave the social worker the following explanation. He informed the social worker that his son had been poisoned by someone. The father explained how his son had been given a sweet that was poisoned and that made him start to have "the strokes". When the social worker asked whether he had been to the clinic to see a doctor about his sons condition he replied that he had but indicated that he did not take what the doctors said seriously as he firmly believed that his son did not have a medical condition.

The father indicated that his son struggles to speak. The father did not see this as a result of other medical complications but gave the following explanation. When his son was poisoned the poison affected his tongue and made it into the shape of a snakes tongue and that was why he struggles to speak. The social worker identified that the "stories" told by the father about his son are not unusual as many people have misconceptions and myths as how someone develops epilepsy. The social worker decided to go through some education with the father as to what

epilepsy is and try to show the father that his son has a medical condition and needs to take medication and have regular medical appointments. Even after going through the educational talk with the father it did not appear to have made a difference.

The social worker asked what clinic the father attends to obtain medication for his son. The father could not give accurate details as to what hospital the child goes to for check ups and to his receive epilepsy medication. The father could not grasp the importance of his son taking medication. The Social worker asked what school the child attends. The father could not tell the social worker what school or what grade the child is in nor when he first went to school. The father has sought no intervention to assist with his son's speech problem. The Social worker decided to take what little information was available and further investigate to piece together the history of the child.

After numerous contacts with various clinics in the area the social worker located a clinic in Place M that had a case file for the child. After speaking to the sister in charge it became evident that the father of the child never showed up for the scheduled medical appointments for the child. The father consistently did not collect medication for the child. The sister in charge said that the father was often told about the importance of his child taking his medication in order for the child to not have so many seizures, his epilepsy would be under better control and he would be to live a healthier life and be able to concentrate in school as well as not being a risk to himself should he have a seizure in a dangerous area etc.. This did not change the father's behaviour. It also became evident that this case had been referred to Child Welfare Place S but no further information was able to be provided.

The Social worker also contacted various schools in the area where the father thought the child may be attending but was not able to locate the school. The Social worker then contacted Child Welfare Society in Place S and was informed that the case of the child had been closed and no further investigation had taken place. A discussion was held with the Social worker at Child Welfare who agreed that the case needed to be re-addressed urgently. A joint meeting was arranged via the farm manager for the father, child, Child Welfare Social worker and Organisation 1 social workers to meet at the Child Welfare Place R offices. On the day of the appointment there was a no show from the father. The Social workers decided to conduct a home visit. The house was not clearly visible and after finally knocking at the door it was evident that nobody was home. The community was very helpful and pointed the Social workers in the direction of the "aunty" of the child. This did not render much success, however information regarding the school was given and the Social workers went to the school.

The Social workers were directed to the class of the child concerned. Upon meeting the class teacher it became evident that:

- 1) They did not know that the child concerned had epilepsy. The teachers could not understand why the child was not progressing in class. They also noticed a bad speech problem and told the Social worker how the child could not even give his full name. They also told the Social Workers how he was always day dreaming in class. The teachers realising the problem that the child has, had already referred him to the regional school psychologist however this assessment would take months.
- 2) The community brought the child to the school as they realised that the father was not able to meet the educational needs of the child

The child was brought into the class and presented as a sickly undernourished child. His clothes were torn and broken and he was unable to hold one single sentence. The child concerned is 10 years of age and he is only in grade 2, even in this grade he could not even cope.

This case displayed a series of gross human rights violations:

- Firstly his right to social security
- Right to education-If it was not for the community the child would not be attending school at all. However there has been a failure on the education department side for not following up sooner on the child's progress. Given the child's evident medical concerns and obvious intellectual impairment the fact that he has had to wait and will wait so long for a referral to a special school is a violation of his right to education.
- Right to medication/healthcare. The care giver of the child has consistently violated the child's right to access medication he needs in order to function in everyday society. By not taking his medication his seizures are not under control and he is at risk for serious injury as well as not being able to reach his full potential. The fact that his speech impairment and evident intellectual impairment has not been properly assessed or addressed is again a violation on his right to healthcare.
- Child Care Act: It is evident that the child father is not in a position to care for the child. The child's physical, emotional and mental state has been negatively affected by the lack of care by his caregiver as well as a lack of intervention on the side of the state that is meant to care for vulnerable children. We are not even aware as to what the child has been exposed to before intervention took place as it is evident that the father was unable to provide for the basic needs of the child let alone providing a safe environment. The father clearly made no attempt at creating a safe environment for the child and it was left to the community to meet the needs of the child.

Intervention:

The Social workers discussed what had occurred and an immediate referral was made to Child Welfare. By doing this referral the following rights would be addressed:

- The child would be placed into an environment that is safe and can meet his basic needs which include food, shelter and emotional care.
- The child medical care would be immediately addressed
- The child would receive financial contribution from the state to meet his financial needs
- The child's education placement would be addressed as a matter of urgency
- The Social workers from Organisation 1 gave information to the school about epilepsy and availed themselves should the school request training about epilepsy. The school unfortunately has not been forthcoming. Attempts have been made to access schools in the area for conducting epilepsy training this is still underway.
- Organisation 1 also availed themselves to child welfare for any assistance that they may require

Case 7: Waiting times at clinics and denial of access to information

A woman went to the clinic early in the morning (6am). She was hypertensive so she needed the medicine immediately that day since it is bad to skip treatment for a chronic condition. This woman waited and waited but by 10:30 she still had not been seen and she was fed-up. She went to ask for her file so that she could go to another clinic where she might be seen but the clerk refused to give her the file.

Case 8. Denial of access to medicine

Mrs Y was at the clinic with a fever. When the nurse (sister) came to see Mrs Y, she told the nurse that she had a fever and needed flu medicine. The nurse then laughed and said that Mrs Y will never get flu medicine- her illness will just go away with time. Mrs Y was shocked that there was no flu medicine at the clinic but the nurse told her not to open a discussion because there are other people waiting outside to be seen. Mrs Y asked, "But where must I go to get the medicine?" The nurse told her that she must go to the Chemist. Mrs Y explained that she was not working and did not have the money to purchase the medicine. Mrs Y also felt that the nurse

could have at least called the dispenser to inquire whether there was flu medicine available or provided further information on why she believed there was no medicine rather than dismissing her so quickly.

Case 9. Termination of pregnancy and hysterectomy

Spoke of a young woman who had gone for a TOP at Hospital B. Two days after the TOP she presented with severe pain and was admitted to hospital where she had an emergency hysterectomy. At no point was she informed why she needed a hysterectomy and she indicated to the counsellor that she had still wanted to have children.

Indicated that they are increasingly seeing cases (3 in 2008) where people are going for a termination of pregnancy at a state hospital and end up having a hysterectomy. It seems to her as if it is a kind of involuntary sterilisation for poor women of colour who have unwanted pregnancies.

Context:

These case studies were collected from a group of home based carers in a township outside of Cape Town. There were approximately 15 women in this group. The same person may have told a number of different stories (cases). A core group of five or six women spoke repeatedly of their experiences

Case 1.

I went to the day hospital, for treatment for myself. The nurses there don't care about people. They don't explain things to people. There was this patient, he was very ill. I think he was HIV positive. He was vomiting. The nurse wanted to make him clean the floor. I told the nurse it was her job to clean the floor as she was working at the clinic. She refused. Eventually I went and fetched a mop to clean up the vomit. I tried to complain about this incident to the head nurse at the facility, but I could not find her. I am sorry that I forgot to take that nurse's name.

Case 2.

I accompanied a patient who was very sick and weak to the day hospital. As the man was practically unconscious I had someone with me to help me to carry this man. When we got to the gates of the clinic they refused to let the helpers in to help to get this man into the building. As there was no one to help me with him, I left him outside and went in to see if I could get a wheelchair. The only wheelchair I could find was full of blood and I couldn't use it. I was worried about the patient outside as I knew he needed help immediately. I asked one of the nurses to help me to find a wheelchair. When we got outside the man was on the point of dying. They eventually took him into the health care facility on a stretcher. I went in with him. The doctors asked me if I was his wife. I said that I wasn't and they asked me to go and wait outside.

Later they came outside and said I should call his wife on the phone, because she needed to be with her husband. I called her, but when she got to the clinic they would not let her in at the front gate. Finally they made an announcement on the intercom asking them to let her in at the front gate. When she came in they told her to sit down and wait. She was hysterical screaming and asking what was wrong with her husband. The doctor came and told her that her husband had passed away. People are dying in these day hospitals.

Case 3.

Once late at night I took a young boy to the day hospital because he had swallowed a five cent piece. The people at the day hospital joked about it saying he would make more five cent pieces. They took an X ray and they could see the five cent piece inside him. But they said there was nothing they could do for him. They advised me to give him small sips of water and that

maybe it would come out by itself. If it was not out of him by morning they said I should take him to Red Cross Hospital. They did not give me a referral letter for Red Cross Hospital. You cannot go there if you don't have that letter. I carried the boy home again. Later he tried to vomit and eventually he vomited the five cents out.

Case 4.

I visited the day hospital because I have high blood pressure. I wake up at 4 am and go early to make sure that the doctor will see me. That morning we were waiting and waiting for someone to see us. We were sitting in the passage and grumbling about how long it was taking while the nurses were in and out of the office. One of the nurses forgot to close the door to the office and I decided to stick my head into the office and ask what was taking so long. When I looked into the office the doctor was sitting there, he was not busy with anyone. He was just sitting and reading the newspaper.

When he was on his way out for tea time I decided to give him a piece of my mind. This doctor was a white man. Even though it is easier for me to speak in my language when I am angry, I spoke to him in English because I wanted him to understand what I was angry about. I told him when you finished studying to do this medicine you raised your hand up to God and said you would serve the people. But you are not serving us the way that you should. You are not serving us because we are black people, instead you are coming here and trying to kill us. How can you be going to tea when you haven't even done any work, there are sick people waiting to see you. I stuck my head in the office and saw you reading the newspaper. But you didn't see me, because you were behind the newspaper. He looked as if he couldn't decide what to do, but in the end he went for tea anyway.

When he came back he brought two student doctors with him. He pointed to her amongst all the people and asked the student doctors to see her. She said that she wanted him to see her and not the student doctors. In the end she was seen by the student doctors. They told her that her blood pressure is very high and that she should go to room 29 for further treatment. She said that she didn't care about treatment and that she was not sick anymore, she was just angry about what the other doctor had done. She told them what had happened with the other doctor, they apologised to her. But she just went home without getting any medication or treatment for her high blood pressure.

Case 5.

We know that these black nurses at the clinic they drink. They carry around tins of coke, but inside these tins is not coke its liquor. This makes them need to go to the toilet a lot. When they go to the toilet they lock themselves in. They keep the keys to the toilets in the clinic with them at all times, so that patients can't use the toilets in the clinic.

When the patients confront them about this they say they won't let them into the toilets because they make a mess. So the nurses tell patients they must go to the public toilets outside. But there are cleaners for the toilets, so why do they do this. They only open these toilets for patients who need to give the doctors urine samples.

Case 6.

I work at an Early Childhood Development (ECD) centre or crèche in the community. The nurses are supposed to go to all the ECD's in the area to do vaccinations with the children. They are supposed to come and give them those drops for polio, but on the date that they were supposed to come they didn't arrive.

I was worried and so I asked the parents to rather take their children to the clinic for the vaccinations. They had to take time off work to take their children to the clinic. The people there at the clinic they don't care about us. When these parents took their children to the clinic, they said they couldn't vaccinate the children because the date for it is over. They said to those parents "maybe you can come again next year". So some of the children haven't till now been vaccinated for polio.

Case 7.

When you go to the doctor, you know what you feel in your body. But these doctors they don't listen to you. He doesn't listen when you tell him that the medicine (for high blood) is making you feel bad, making you feel very hot and making your tears come down and making you not able to sleep. He doesn't believe you and he argues saying he knows best because he studied medicine. If you argue too much about the medicines then they will refuse to even give you a prescription.

That is why I have stopped the treatment now, I don't get medicine from the day hospital anymore and so now I have to go to the chemist to get my pills.

Case 8.

If you have bad arthritis and you have swollen hands and feet. You can't work because of this and you show the doctor your feet are so swollen. You say you need a grant because you are not employed and you have a family to support. The doctor said to me you are still young go and look for work.

But I am still unemployed and when I go and look for work they tell me I am too old and they tell me to bring my son or my daughter.

Case 9.

My daughter is 24 years old, she was pregnant and had a baby in March last year. The baby was very small, but when I asked them about it at the hospital they said that the baby was normal and that there was nothing wrong. Later my daughter had to take the baby to the clinic. When she came back from the clinic she was crying and crying. When I asked her what was wrong she told me that the nurse at the clinic had spoken to her in front of all the other ladies and asked her why this baby is so small, she asked her in front of everyone if the baby is HIV positive.

I took my daughter and went to that nurse. I didn't speak to her in front of all the other patients. I called her aside and spoke to her. I said to her that she had upset my daughter and made her cry by asking her in front of everybody if the baby was HIV. I said that it wasn't necessary to ask her that in front of everybody. I said surely they must have the baby's file from the hospital and they would have information in there that confirmed that the baby is not HIV positive.

I told that nurse that the nurses at clinics are very rude to people and that I want to make a big example of her by taking a complaint about how she had treated my daughter. That nurse was crying and she apologised to me. But I said you should not apologise to me but to my daughter.

Case 10.

My mother is very old and she has to go to hospital X for her treatment. But because of the rules at the hospital she has to go in there alone. I can't go in with her to help her. And she is so sick that she can't speak, so no one will know what is wrong with her.

If you want to complain about something they always say you must speak to the head sister, but the head sister is never available, so you can't speak to her. You can also put a complaint in the complaints box, but nothing ever happens.

Case 11.

This case illustrates the severe lack of caring from the nurses. People wake up very early at 4am to go to the clinic and sometimes only get to be seen by 4pm or even 6pm. Yet staff at the clinics have these long meetings which means that there is no doctors or nurses available to see anyone. The only people that are available are the nursing assistants and they can't help you.

Also people come to the clinic with really bad wounds. They should be treating these wounds in a separate room. But instead they open them in the general area and it means that the clinic is stinking all the time and you can't even eat in there. Once I also took my child to the clinic when she was sick. When she vomited the nurse told me I had to clean it up, because it was my child that made a mess.

Case 12.

Your folder at the clinic normally has your whole medical history in it. They look at your whole file to make a decision about giving you a disability grant. If you are lucky and the doctor agrees to apply for a grant for you, then they use your file. The doctor will normally tell you to come back on a certain date, but when you get there then they tell you that they have lost your folder. But actually they haven't lost your folder, some of the staff are using your folder, using your information to get a disability grant for someone else.

Because they haven't got your folder then they open a new folder for you at the clinic, but because this doesn't have all your information in it then you won't get a grant. So now what we do is if the doctor agrees to apply for a grant for you then it is important to know that you should steal your folder. We put the folder under our clothes or in a bag and take them home with us. Then we bring the folder back on the date they said to come so that we make sure that we can get the grant.

Case 13.

Once I took my son to the clinic, he has epilepsy. While we were there I saw another boy there. He had serious wounds, he had stab wounds all over his body and his face and parts of his body were covered with sand. It was winter at the time and it was very cold. The nurse brought him a big bucket of cold water. She put it down in front of him and told him to wash himself. He couldn't wash himself, he could hardly move properly. I asked the nurse why she wasn't going to help him. She said it was because she wouldn't touch blood. Even though there were gloves available she refused to help the boy wash. I really wanted to help him, to put gloves on and help him wash, but I couldn't leave my son alone. There was nobody else who could help him.

Nowadays if you come to the clinic with someone you have to wait for them outside the gates of the clinic. You can't go in with them to help them. And to wait outside the gates of the clinic is dangerous.

Case 14.

If the doctor can't understand what you are telling them there are nurses who can interpret for you. But these nurses don't tell the doctor exactly what you have said. Because the nurses tell the doctor the wrong thing, then the doctor gives you the wrong medicine.

Case 15.

The doctors at the clinics don't examine people anymore. I don't know what has made the doctors at the clinic stop examining people. They just listen to what you say and then write a prescription. Before they used to let you sit on the bed and listen to your heart and check you out.

I went to the doctor at Clinic X. The doctor was an old man. I had something like the flu. I was feeling very hot and weak. The doctor just wrote down the medicine that I must get. When I asked him if he wasn't going to examine me, he told me to take off my panty. There was no problem with my womb, but he gave me a vaginal examination. He pricked me so badly that it made me get more sick. I felt so weak that I didn't do anything about what he had done. But now I don't ever ask the doctors to examine me anymore, I am too afraid.

Case 16.

I was working at the old age home and I had severe stomach pain. They took me to Hospital Y in Place Z. They saw a ball inside me, in my womb (a growth). They said it would need to be removed and so I had to go for an operation. When they did the operation they saw that I had a baby inside me. The specialist who said I needed an operation didn't think that it might be a baby. He didn't see that it was there. They stitched me closed and the baby survived. The daughter that was born is 15 years old now.

Case 17.

I was working as a staff member at Hospital S. The staff doctor was an old man and I complained to him that I had a bad pain in my side. This doctor gave me some Panado's for the pain. I still had the pain in my side. They did a pregnancy test that came back positive, but there was no baby in my womb. They carried on giving me pain medication. At this time I had so much pain I could not walk. When a different doctor treated me he told me that there was a baby in my tubes. By this time the damage was so bad that I had to have a hysterectomy.

Western Cape Submission

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– review on progress on the Right to Health –

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