

**South African Human Rights Commission, National Human Rights
Institution Report**

on

**Initiatives that exemplify good or effective practices in adopting a
human rights based approach to eliminating preventable maternal
mortality and morbidity**

This report is submitted to the United National High Commissioner for Human
Rights
in terms of written correspondence dated 13 January 2011 requesting information
pursuant to Resolution A/HRC/15/17 entitled, “Preventable maternal mortality and
morbidity and human rights: follow up to Council Resolution 11/8”, which was
adopted by the Human Rights Council in September 2010

Report Submitted - 1 April 2011



INDEX

Introduction	3
1. Section 184(3) Report on Economic and Social Rights	3
2. Public Inquiry: Access to Health Care Services Report	6
3. Participating in parliamentary processes	7
4. Complaints Handling Mechanism	9
Conclusion	9
Annexures	
“A” Background information	10
“B” Definition of Terms Maternal Mortality in South Africa	12
“C” Additional information on NGO submissions made to the SAHRC Inquiry into Access to Public Health	14

Introduction

In response to the formal request of the Office of the High Commissioner for Human Rights to share “initiatives that exemplify good or effective practices in adopting a human rights-based approach to eliminating preventable maternal mortality and morbidity,”¹ the South African Human Rights Commission (“SAHRC” or “Commission”) has prepared this report to explore the initiatives that the SAHRC has undertaken in order to promote maternal health as a constitutionally protected right. In the fulfilment of its role as South Africa’s recognised national human rights institution (“NHRI”) and in terms of its monitoring mandate², the Commission has consistently reported its findings in its periodic reports drafted in terms of section 184(3) of the Constitution; has held a specific inquiry into the challenges facing access to health care, and has worked in parliament to ensure that maternal rights are protected through relevant legislation. The Commission can also address health issues through its complaints handling mechanism.

1. Section 184(3) Report on Economic and Social Rights

Section 184 (3) of the South African Constitution specifically mandates the SAHRC to monitor the implementation of economic and social rights by major organs of state through annual requests of each organ’s efforts and measures to the realization of these rights. The Commission has developed a methodological questionnaire sent to relevant departments listing these bodies’ systems of monitoring and information gathering and relevant policies and measures that have been introduced towards the realisation of human rights.

The Commission structured its most recent Economic and Social Rights (ESR) Report around South Africa’s fulfilment of the Millennium Development Goals (MDGs). MDG 5 specifically deals with the critical issue of maternal mortality. According to the findings of the Commission, “South Africa is a far way from reaching the target of reducing the maternal mortality rate by three quarters. In fact the trend is suggesting that it is increasing.”³ The Commission has repeatedly called for an investigation into child and maternal mortality by the Department of Health (DoH) to determine the reasons behind the upward trend.

¹ Office of the High Commissioner for Human Rights. Written correspondence pursuant to Resolution A/HRC/15/17: “Preventable maternal mortality and morbidity and human rights: follow up to Council Resolution 11/8”. (13 January 2011)

² See Annexure ‘A’ for further information regarding the SAHRC’s international recognition, constitutional mandate; South Africa’s relevant international human rights law obligations and relevant provisions of the South African constitution

³ South African Human Rights Commission. *7th Report on Economic and Social Rights : Millennium Development Goals and the Progressive Realisation of Economic and Social Rights in South Africa*. Johannesburg (2010). 92

Information made available to the Commission indicated that the majority of these deaths are due to hypertension, obstetric haemorrhage, pregnancy-related sepsis, and non-pregnancy related infections (of the latter, 45% was accounted for by AIDS). The majority of avoidable factors leading to maternal deaths were patient oriented (43.9%), such as delays in seeking medical help, unsafe abortions, and no antenatal care. Healthcare personnel factors included substandard care, lack of adherence to standard protocol, poor problem recognition, and poor initial assessments⁴. Other contributing factors towards maternal death included: patients being unable to pay for transport due to unemployment (especially in rural areas), and hospitals experience a shortage of professional health care staff.⁵ Administrative factors such as a lack of appropriately trained staff, specific health care facilities, and blood for transfusion also significantly contributed to avoidable maternal deaths. The vast majority of deaths classified as “anaesthesia related” or “postpartum haemorrhages” were portrayed as “clearly avoidable.”⁶

More positively, the Commission noted an increase in access to all public sector facilities and an increase in their usage. The Commission was able to determine that 92% of women were able to access antenatal and delivery care, as health care is free for all pregnant women and the DoH has actively promoted and informed women of this right.⁷ Whilst an increase in attendance has been noted in all provinces, the Commission also noted the uneven distribution of the increases, where rural delivery rates lagged compared to national delivery rates (74.5% compared to 80.6%, respectively, in 2007/2008).⁸ Another study found MMR to only be marginally higher in rural areas as opposed to urban areas (604 vs. 505 respectively), causing the researchers to conclude that the increased incidence in rural areas to be more likely a factor of HIV and other external causes than a lack of access to medical services.⁹

The MMR of women who were HIV infected is almost 10 times that of non-HIV infected women (the latter is comparable to that of other middle income countries).¹⁰ In one

⁴ Ibid 91

⁵ Burnett, P. *South Africa: Redouble Efforts to Reduce Maternal Mortality*. AllAfrica.com (2009) sourced at [Mhttp://allafrica.com/stories/200909100887.html](http://allafrica.com/stories/200909100887.html)

⁶ NCCEMD. *Maternal Deaths Report*. (2006) sourced at <http://www.info.gov.za/view/DownloadFileAction?id=70073>> 9

⁷ South African Human Rights Commission. *7th Report on Economic and Social Rights*. 92

⁸ Ibid

⁹ Garenne, M., McCaa, R., and Nacro, K. *Maternal Mortality in South Africa in 2001: From demographic census to epidemiological investigation*. Population Health Metrics 6:4 (2008) sourced at <http://www.pophealthmetrics.com/content/6/1/4/>

¹⁰ Burnett, P. *South Africa: Redouble Efforts to Reduce Maternal Mortality*

study, tuberculosis and HIV-1 emerged as significant contributors to maternal mortality in KZN.¹¹ Another study found that HIV increases pregnancy-related sepsis.¹² Thus, any measures to address communicable diseases are also directly applicable to maternal health. MDG 6 is specifically concerned with combating HIV/AIDS, malaria, and other diseases. South Africa's target is to have halted and begun to decrease the spread of HIV/AIDS by 2015. The Commission found that the government has specifically taken strides in decreasing the HIV prevalence among pregnant women aged 15 to 24 years. This decline has been documented in antenatal clinic attendees in all provinces except Free State.¹³ The Commission encouraged the government to set a distinct and quantifiable target to properly measure their progress on this MDG. The DoH has been criticized as having not taken enough initiative in informing mothers of their rights concerning HIV/AIDS, so health care practitioners (and consequently mothers) are less aware of services intended to prevent mother to child transmission (MTCT).¹⁴

However, the DoH has implemented a MTCT prevention programme, which has likely contributed to the documented steady increase in HIV maternal testing.¹⁵ The universal coverage of testing is likely to further improve with the intended implementation and extension of comprehensive care, management, and treatment plans (CCMTP) for HIV/AIDS.¹⁶ The government has developed "relatively strong national policy on safe motherhood and curricula for training health care providers" but has plagued by shortages in resources.¹⁷

The Report was tabled in Parliament in December 2010. In terms of procedure the Report will be allocated to a parliamentary Portfolio Committee to consider before it is adopted. The Report was also distributed to the relevant government departments and responses to the recommendations were requested. Moving forward, during the 2011/2012 financial year commencing 1 April 2011, the Commission has planned to establish a monitoring and evaluation database to track the impact of its recommendations.

¹¹Khan, M; Pially, T.; Moodley, J; Connolly, C. *Maternal mortality associated with tuberculosis-HIV-1 co-infection in Durban, South Africa*. Durban Perinatal TB HIV-1 Study Group. AIDS: Vol. 15 (14) (2001) pp. 1857-1863 sourced at <http://journals.lww.com/aidsonline/Abstract/2001/09280/Maternal_mortality_associated_with.16.aspx>

¹² Dawes, A. (Ed.) *The state of children in Gauteng. A report for the office of the Premier, Gauteng Government*. Pretoria: Child Youth and Family Development, Human Sciences Research Council. (2003) sourced at <http://www.hsrc.ac.za/research/output/outputDocuments/2387_Dawes_StateofchildreninGauteng.pdf> 18

¹³ which had a 3% documented increase in the same group

¹⁴ Burnett, P.) *South Africa: Redouble Efforts to Reduce Maternal Mortality*

¹⁵ NCCEMD. *Maternal Deaths Report*. 4

¹⁶ Ibid, 5

¹⁷ Maternal and Neonatal Program Effort Index. *A tool for maternal health advocates*. Glastonbury (2003) <http://www.policyproject.com/pubs/MNPI/South_Africa_MNPI.pdf> 7

2. Public Inquiry: Access to Health Care Services Report

The SAHRC has received numerous complaints with regards to poor health care service delivery throughout all South African Provinces. As such, the SAHRC initiated public hearings into the right of health care access, which also served to highlight the lamentable state of maternal health care within the country. Starting May 2007, the Commission embarked on visits to approximately 100 facilities across the country, investigating into the number of complaints relating to general health care access at the time. In addition, the public were invited to make public submissions. These activities culminated in public hearings aimed to assess the barriers of accessing health care services.¹⁸ The hearings were conducted and coordinated under the auspices of the Commission's Legal Services Programme (LSP).

The Commission found poverty to be the main overall inhibitor to accessing healthcare services. The Commission determined that inequalities between private and public healthcare expenditure, communication gaps at the managerial level, staff shortages and stressful conditions, lack of resources, lack of basic communication tools, and discriminatory attitudes towards vulnerable groups were the main limitations to the full implementation of the human right to basic health care.¹⁹ These findings are all reiterated in the submissions received that specifically pertained to maternal rights (see Annexure 'C' for more details).

Many of the submissions called for the development of strategic and comprehensive plans to address overall deficiencies in the health care system that affect maternal rights, such as the development of comprehensive plans for the prevention of MTCT, and to address those already living with HIV/AIDS, for more targeted initiatives to facilitate rural health care transportation, and for further information campaigns so that women know their basic rights as it pertains to their reproductive choices, such as their right for termination of pregnancy.

The Commission found that maternal death, being largely preventable, is directly linked to the access and quality of public health care services of the country. The MMR is thus an important indicator not only of the state of any health care system, but also of the

¹⁸ Karrim, Q. *SAHRC: Govt failing in healthcare provision*. Mail & Guardian Online. (2009) sourced at <<http://www.mg.co.za/article/2009-04-16-sahrc-govt-failing-in-healthcare-provision>>

¹⁹ Ibid

broader well being of the country.²⁰ Confidential enquiries such as those by the National Committee on Confidential Enquiries into Maternal Deaths (NCCEMD) are critical in understanding the cause of deaths and thereafter creating and enforcing appropriate national guidelines and protocols.²¹

This report was launched publicly and received much media attention. It was formally tabled in Parliament. However, the report has not to date, been processed through the relevant parliamentary committee. The report was also sent to relevant government departments requesting a response to the recommendations. The report's recommendations will also be added to the monitoring and evaluation database that will be established shortly.

3. Participating in parliamentary processes

The SAHRC regularly participates in parliamentary processes, ranging from making submissions on draft legislation, participating in parliamentary public hearings on draft legislation or briefing portfolio committees on particular issues of concern. Over the years, the SAHRC has been presented with a number of such opportunities that bring attention to MMR.

The Choice of Termination of Pregnancy Act 92 of 1996 ("the Act") came into effect as of 1 February 1997. The Act allowed women to seek abortions within certain time frames. This legislation was written within the constitutionally protected rights of persons to make decisions concerning reproduction and to security in and control over their bodies, rights to be informed of and have access to safe, effective, affordable and acceptable methods of fertility regulation of their choice, and rights of access of women to appropriate health care services to ensure safe pregnancy and childbirth."²²

In 2007, the SAHRC sent a letter to parliament formally welcoming further amendments to the Act which would increase women's access to safe legal abortions. The Act and its amendments have been successful in increasing the number of legal terminations while decreasing illegal terminations, leading in a decline in the total number of documented

²⁰ South African Human Rights Commission. *Public Inquiry: Access to Health Care Services*. SAHRC: Johannesburg (2010). Sourced at <<http://www.rhap.org.za/wp-content/uploads/2010/05/Access-to-health-care-services-SAHRC-report.pdf>> 21

²¹ Ibid.

²² Acts Online. *The Choice on Termination of Pregnancy Act, 1996. (Act No. 92 of 1996)* (January 1996) <<http://www.acts.co.za/>>

terminations.²³ This was shown in the findings of the Second Confidential Enquiry into Maternal Deaths in South Africa, conducted between 1999 and 2001, which showed that there was a 90% reduction in abortion related deaths per year after passing the Act. Over the five-year period leading up to the implementation of the Act, health facilities were admitting hundreds of women with incomplete abortions, of whom 450 died annually.²⁴

In May 2010, a Member of Parliament, the Honourable Cherylyn Dudley of the African Christian Democratic Party (ACDP) sought to make use of Parliament's private members bill to introduce amendments to the Act through introducing the Choice on Termination of Pregnancy Amendment Bill ("the Proposal"). The Commission submitted a report and appeared before the parliamentary committee, playing an important role as the mouthpiece of human rights within South Africa as it pertained to the issue of abortion.

The Commission took issue with multiple clauses in the Proposal, stating that:

- a) The renewed requirement in the Proposal was already written into regulations under the principal Act, and that any subsequent legislative proposals trying to ensure sufficient information for those seeking termination is redundant. These requirements would stretch out already insufficient personnel and money available to offer services and would hinder access to legal and safe terminations.
- b) The Commission held that the Proposal's requirement to show the woman pictures of the foetus would impose unnecessary trauma on any woman who did not actively choose to see photos. Commission Chairperson Lawrence Mushwana emphasized the need to see emotional burdens reduced, and stated that the Proposal's requirement implied interrogation of women seeking abortions as opposed to creating a supportive environment of informed consent.
- c) The links designated between termination of pregnancy and depression, breast cancer, and any other negative side effects as asserted in the Proposal should not be assumed, but rather be medically proven before being written into legislation.

²³ Parliamentary Monitoring Group. *Dudley Proposal: choice on Termination of Pregnancy Amendment bill: Further comment*. (4 June 2010) sourced at <<http://www.pmg.org.za/report/20100604-dudley-proposal-choice-termination-pregnancy-amendment-bill-presentat>>

²⁴ South African Human Rights Commission.. *Chapter Five Health Care and Health Care Services for Children*. SAHRC: Johannesburg (2002) sourced at <http://www.sahrc.org.za/home/21/files/Reports/3rd%20ER%20report%20chapter_5.pdf> 210

- d) The usage of the word “unborn child,” as written in the Proposal, is not in line with South African case law. The Commission rather supports the usage of the term “foetus” as previously used in the principal Act.²⁵

The Centre for Applied Legal Studies and the DoH were among the organizations that concurred with the Commission’s position, deeming the Proposal inappropriate to be written into the Act.²⁶ The key stakeholders “overwhelmingly concluded that there was no need for the amendment”²⁷ and the Proposal was ultimately rejected on 20 October 2010.²⁸

4. Complaints Handling Mechanism

The SAHRC has, as an essential function, the role “to take steps to secure appropriate redress where human rights have been violated.”²⁹ This function is carried out through its complaints handling mechanism. The Commission is currently investigating the deaths of premature babies in a number of hospitals in South Africa. The investigation has included high-level meetings with the Minister of Health. The investigation is ongoing and its findings will be published. If human rights violations are identified, recommendations will be made to the relevant government departments. It is through this mechanism that public inquiries such as the above-mentioned Access to Healthcare Report are founded.

Conclusion

In line with its constitutionally mandated role, the Commission has consistently engaged with the DoH and other relevant state parties in order to ensure the appropriate and adequate delivery of services to pregnant women. More than just the provision of free and accessible services for pregnant women and children is needed. This vulnerable group requires genuine empowerment, improved provision of essential services and the

²⁵ Parliamentary Monitoring Group. *MP’s Legislative Proposal to Amend Choice on Termination of Pregnancy Act; Prevention and Combating of Trafficking in Persons Bill public hearings: consideration*. (1 September 2010) sourced at <<http://www.pmg.org.za/report/20100901-consideration-private-members-legislative-proposal-amend-choice-termini>>

²⁶ Parliamentary Monitoring Group. *Dudley’s Proposal to amend Choice on Termination of Pregnancy Act: Centre for Legal Studies and Commission on Gender Equality*. (28 May 2010.) sourced at <http://www.pmg.org.za/report/20100528-dudleys-proposal-amend-choice-termination-pregnancy-act-centre-applie>

²⁷ Parliamentary Monitoring Group. *Dudley’s legislative proposal on Choice on Termination of Pregnancy Amendment Bill: rejection*. (20 October 2010.) sourced at <<http://www.pmg.org.za/report/20101020-dudleys-legislative-proposal-choice-termination-pregnancy-amendment-b>>

²⁸ Ibid

²⁹ Constitution of the Republic of South Africa 1996, Chapter 9 Section 184

improvement of their socio-economic environment,³⁰ rights that South African Human Rights Commission is designed and prepared to protect.

³⁰ NCCEMD. *Maternal Deaths Report*

Annexure “A”

Background information

International recognition as NHRI

The SAHRC is recognised by the United Nations Office of the High Commissioner for Human Rights (OHCHR) as an ‘A’ status national human rights institution (NHRI).

The Constitutional Mandate of the Commission

Established by section 184 of the Constitution, the Commission is an independent state institution that is mandated to:

- a) promote respect for human rights and the culture of human rights,
- b) promote the protection, development, and attainment of human rights,
- c) and monitor and assess the observance of human rights in the Republic.³¹

In terms of section 184 (2) of the Constitution, the Commission has powers to perform the following functions:

- a) to investigate and to report on the observance of human rights;
- b) to take steps to secure appropriate redress where human rights have been violated,
- c) to carry out research, and
- d) to educate.³²

Additional powers and duties of the Commission are set out in the Human Rights Commission Act 54 of 1994.

Relevant international instruments and constitutionally guaranteed rights

The rights of women are enshrined in multiple human rights instruments and mechanisms to which South Africa is party, including the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW), the Beijing Declaration and Platform for Action, the UN Committee on the Status of Women (CSW), the Maputo Protocol, the SADC Protocol on Gender and Development,³³ and the UN Human Rights Council’s Resolution on Preventable Maternal Mortality and Morbidity and Human Rights.³⁴

In addition the Constitution specifically protects the maternal rights of women in the following sections:

³¹ Constitution of the Republic of South Africa 1996, Chapter 9 Section 184

³² Ibid

³³ Private Members proposed Choice of Termination of Pregnancy Amendment Bill 2010. *SAHRC comments to the Portfolio Committee on Private Members’ Legislative Proposals and Special Petitions*. Annexure 4. (4 June 2010)

³⁴ ACHPR. *27th Activity Report of the African Commission on Human and Peoples’ Rights Submitted in Accordance with Article 54 of the African Charter on Human and Peoples’ Rights*. African Union, Banjul, The Gambia. Sourced at <[http://www.ccpau.org/Portals/0/xyiznwsj/EX%20CL%20575%20\(XVI\)%20Report.pdf](http://www.ccpau.org/Portals/0/xyiznwsj/EX%20CL%20575%20(XVI)%20Report.pdf)> 22 N124

- a) Section 27(1)(a) of the Bill of Rights: “Everyone has the right to have access to health care services, including reproductive health care...”³⁵
- b) And Section 12(2) of the Bill of Rights: “Everyone has the right to bodily and psychological integrity, which includes the rights to make decisions concerning reproduction and to have security in and control over their bodies.”³⁶

These aforementioned rights guarantee the right of women to choice and control over their bodies and their own reproductive decisions; rights that are legislatively those that the Commission is designed to protect.

³⁵ South African Government Information. *Chapter 2- Bill of rights*. Section 27 (1) (a) sourced at <<http://www.info.gov.za/documents/constitution/1996/96cons2.htm>>b.<http://www.info.gov.za/documents/constitution/1996/96cons2.htm>

³⁶ Ibid. Section 12(2) a. b.

Annexure “B”

Definition of Terms

The internationally accepted definition of maternal death is the “deaths of women while pregnant or within 42 days of termination of pregnancy from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes”.³⁷ This definition was used in South Africa by the National Committee on Confidential Enquiries into Maternal Deaths (NCCEMD), a committee created by the Department of Health (DoH) of South Africa in order to survey the causes of maternal deaths to create better protective policies for this group.

Likewise, the maternal mortality ratio (MMR) is defined as the average number of deaths for every 100,000 live births. MMR of a country is a direct indicator of obstetric service quality, but is a sensitive indicator of the status of women within a country, and of the access to health care and the adequacy of the health care system in responding to their needs.³⁸

For this reason, the protection of maternal rights is enshrined in many international human rights instruments. Maternal mortality is specifically addressed as the fifth Millennium Development Goal (MDG): to improve maternal health by reducing the MMR by three quarters from 1990 to 2015 and by achieving universal access to reproductive health by the same date.³⁹

Maternal Mortality in South Africa

In the 2010 Medium-term budget policy statement, South African Finance Minister Pravin Gordhan stated that there was an “alarming” upward trend in MMR in recent years.⁴⁰ According to a Lancet study done in August 2009, “an estimated total of 76,600 women, neonates, and children die unnecessarily every year”⁴¹ in South Africa.

Despite no recent statistics or surveys that can accurately determine the MMR for South Africa, all estimates demonstrate that the MMR for South Africa is exceedingly high for a middle-income country. The most recent numbers range anywhere from 124 to 646 per 100,000 births.⁴² However, these numbers vary widely depending on the organization.⁴³ There have also been major inconsistencies in data gathering within the country,

³⁷ South African Human Rights Commission. 7th Report on Economic and Social Rights. 83: note 275

³⁸ Dawes, A. (Ed.) *The state of children in Gauteng*. 18

³⁹ World Health Organization. *MDG 5: Improve maternal health*. Sourced at <http://www.who.int/topics/millennium_development_goals/maternal_health/en/index.html>

⁴⁰ News 24. *Alarming rise in maternal deaths*. Cape Town (27 October 2010) sourced at <<http://www.news24.com/SouthAfrica/News/Alarming-rise-in-maternal-deaths-20101027>>

⁴¹ Burnett, P, *South Africa: Redouble Efforts to Reduce Maternal Mortality*

⁴² South African Human Rights Commission. 7th Report on Economic and Social Rights 91 and Garenne, M. et al. *Maternal Mortality in South Africa in 2001*.

⁴³ Health Systems Trust. *Health Statistics: Maternal mortality ratio (MMR)*. (2007) sourced at <<http://www.hst.org.za/healthstats/32/data>>

especially with sensitive areas such as termination of pregnancy services.⁴⁴ Nevertheless, all estimations indicate the same “alarming” upward trend described by Minister Gordhan. For instance, Statistics South Africa estimated the MMR at 165.6, a significant increase from 84.25 in 1998.⁴⁵

⁴⁴ South African Human Rights Commission. *7th Report on Economic and Social Rights*. 79

⁴⁵ *Ibid* 91

Annexure “C”

Additional information on NGO submissions made to the SAHRC Inquiry into Access to Public Health

The AIDS law project (ALP), the National Education, Health, and Allied Workers Union (NEHAWU) and the Treatment Action Campaign (TAC) agreed that holding enquiries and inviting submissions concerning key human rights legislation and debates was “necessary and fully in keeping with the SAHRC’s constitutional and statutory responsibilities.”⁴⁶

The submission from the Access to Safe Motherhood group in May 2007 revealed that at least 37% of maternal deaths were avoidable. They found that care is not patient-centred, that staff are inadequately trained, managers are accountable for financial management (as opposed to quality of care), and some essential services are not comprehensively available (e.g. doctors available for caesareans).⁴⁷ The group found that the poor treatment of women is commonplace and midwives and doctors are extremely unmotivated. This is reiterated by the Research from the Centre for Health Policy, whose findings indicated that midwives were overworked and underpaid, with no potential for advancement, and with no remuneration for extra experience, training, and managerial responsibilities. Additionally, midwives generally work in poorly managed facilities that are resistant to change from rural informal policies.⁴⁸

The Safe Motherhood group furthermore objected to the lack of integration of HIV/AIDS and maternal health care services. The ALP, NEHAWU, and TAC submission reported that an estimated 60,000 children were infected through MTCT in 2005. This high number persists despite a 2002 constitutional court order for the government to implement a national programme to prevent MTCT. The court found that the state’s “policy was an inflexible one that denied mothers and newborns opportunity to lifesaving drugs, potentially administered within available resources of the state without any known harm to mother or child.”⁴⁹

Safe Motherhood’s submission fit with the Commission’s overall findings that poverty and a lack of government resources were significant contributing factors to the lack of decent health care for these women. The group found that 40% of poor women were not accessing services in the Eastern Cape, due to:

- a) the poor status of women in their communities

⁴⁶ AIDS Law Project (ALP), National Education, Health and Allied Workers’ Union (NEHAWU), Treatment Action Campaign (TAC). *Submission to the South African Human Rights Commission enquiry into access to health care services*. (17 April 2007) sourced at <<http://www.section27.org.za/wp-content/uploads/2010/04/Access-to-Health-Care-Services-2007-Joint.pdf>> 2

⁴⁷ South African Human Rights Commission. *Public Inquiry: Access to Health Care Services*. 47-48

⁴⁸ Ibid 36

⁴⁹ ALP, NEHAWU, TAC. *Submission to the South African Human Rights Commission*. 17-18

- b) the lack of women's trust in the health care system
- c) the lack of funds for treatment and for transport
- d) the lack of ambulances
- e) the less-than-optimally functional emergency transport system
- f) and the gate keeping role of clerks and health care workers.⁵⁰

⁵⁰ South African Human Rights Commission. *Public Inquiry: Access to Health Care Services*. 42