

# HEALTH SECTOR

Gender Empowerment for Radical Socio-Economic Transformation





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# 1. INTRODUCTION

This paper has been prepared as an input on Health into the Gender Policy Discussion Paper. The purpose of the paper is to elucidate achievements that have been made on gender empowerment in respect of health since the dawn of democracy. The paper also explores weaknesses that still persist in further achieving gender equity as it relates to health and programmes that must be pursued to contribute to radical socio-economic transformation of women through health and health services.

The last 20 years in South Africa's democratic history have been marked by two outstanding achievements namely: the birth of a constitutional state and the constitutional commitment to eliminating racial and gendered discrimination. The formal promulgation of the Constitution of the Republic in 1996 was an important milestone in further advancing democratization of South Africa and entrenching women's rights and gender equality. Section 27 of the Bill of Rights of the Constitution states that everyone has the right to have access to health services, including reproductive health care; access to sufficient food and water; and access to social security, including if they are unable to support themselves and their dependents, appropriate social assistance.

Furthermore, 2014 marks the 60<sup>th</sup> anniversary of the adoption of the Women's Charter. The women's charter advocates for the protection of mother and child through establishment of maternity homes, welfare clinics, creches and nursery schools, in countryside and towns; through proper homes for all, and through the provision of water, light, transport, sanitation, and other amenities of modern civilization. Article 11 of the Women's Charter for Effective Equality adopted in 1994 by the Woman's National Coalition advocates for the types of health services that are necessary to ensure good health and that women must be entitled to namely:

- i. Equal, affordable and accessible health care services which meet women's specific health needs, and which treat women with dignity and respect shall be provided;
- ii. Women should be made aware of their rights in relation to health services;
- iii. Health services to be appropriately orientated to meet women's health needs and priorities;
- iv. Women have the right to have control over their bodies which includes the right to reproductive decisions;
- v. Access to Information and knowledge to enable women to make informed choices about their bodies and about health care should be provided;
- vi. Education about family planning and family planning services should be provided free of charge to both men and women;
- vii. Every person shall have access to adequate nutrition;
- viii. Appropriate and accessible mental health care services must be provided to women. Basic life sustaining services such as water, sanitation, which ensures good health, must be made accessible to all South Africans by the State.

This discussion document provides firstly the policy context of gender and health; secondly an assessment of where women are in terms of health and gender empowerment and the progress that has been made since the dawn of democracy; thirdly the current challenges that still persist; and lastly what needs to be done in the health sector to achieve radical socio-economic transformation for women.

## 2. CONTEXT OF GENDER EQUALITY AND HEALTH

### a) Political Context

The 2008 ANC Women's League Conference noted: the improvements made in making health facilities and medicines more accessible; the impact of uneven development along racial, gender and class lines that has subjected women unbearable conditions pertaining to health; that women are still burdened with caring for sick, vulnerable family members and children; that women are the most vulnerable sector to easily contract HIV and AIDS; that the escalation of teenage pregnancy is still a serious set-back in emancipating women; that women are still adversely affected by the poor state and capacity of health facilities especially in rural and peri-urban areas; and that women are negatively affected by lack of knowledge on health issues. Conference resolved that access to health facilities should be improved so that lives of poor communities could be improved; ANCWL would be at the centre of the campaign that seeks to raise consciousness about ills of teenage pregnancy, the spread, impact and disclosure of HIV and AIDS; and to lead radical campaigns that would contribute to redressing negative impact of the past pertaining to health as health is critical for human development

The 2012 ANC Policy Discussion Paper on Gender elaborates on certain interventions in health that had to be undertaken as a strategy of advancing the struggle against gender inequality and patriarchy. The paper states that: "Delivery on the four key areas must be accelerated viz, increasing life expectancy; combating HIV and AIDS; decreasing the burden of diseases from Tuberculosis (TB) and improving health systems effectiveness. With special emphasis on deliverables aimed at improving the health status of women and children" consistent with health related Millennium Development Goals (MDG's). The Gender Paper elucidates on the high HIV and AIDS burden; high maternal mortality rate experienced by women; and high levels of gender-based violence that fuels the HIV epidemic in women. The introduction of National Health Insurance is welcome as it introduces programmes through primary health care re-engineering aimed at addressing the high maternal and child mortality related to the health related MDG's.

The 2014 ANC Elections Manifesto prioritises women's health through intensification of the fight to reduce maternal and child mortality and promote women's health through the following interventions:

- In the next five years the ANC will introduce measures to reduce unwanted pregnancies with a special focus on teenage pregnancies. This will encourage child survival, improve the lives of young women and markedly reduce maternal mortality. This will be done through education, information and the launch of a massive contraception and family planning programme;
- To reduce the incidence of cervical cancer of the uterus in women, as from 2014 all girl-children in Grade 4 in government schools will be vaccinated against the human papilloma virus which causes cervical cancer;
- We will implement the African Union-inspired Campaign on Accelerated Reduction of Maternal and Child Mortality in Africa (CARMMA). This will place mother and children, over five years, at the centre of our health care programmes, especially at primary health care level.

### b) Government Context

The National Development Plan (NDP) Vision 2030 has placed a priority on women's and children's health. On maternal and child health, the NDP advocates for improving the quality of antenatal and postnatal care, and on using health information to follow up on patients to reduce unnecessary deaths<sup>1</sup>. Government has prioritised women's health through the 2014-2019 Medium Term Strategic Framework (MTSF). Outcome Number 2 of the Government's Programme of Action is: "A long and healthy life for all South Africans". To reduce the high maternal mortality, Sub-outcome 3 of the MTSF focusses on Primary Health Care (PHC) Re-engineering through the deployment of District Clinical Specialist Support Teams and Integrated School Health Services. To further reduce Maternal, infant and child mortality Sub-outcome 9 of the MTSF focuses on improving the implementation of Basic Antenatal Care, expanding the prevention of mother to child transmission (PMTCT) coverage to pregnant woman; and expanding access to sexual and reproductive health through making available contraceptives and access to cervical and HPV cancer screening services.

### 3. PROGRESS IN RESPECT OF HEALTH AND GENDER EMPOWERMENT

#### i. Free Health Care

Government has also improved access to health care through ensuring free health care in clinics, especially for children and pregnant mothers. All public sector clinics are now within the 5km radius from homes although there are still challenges with regard to staffing shortages and availability of medicines. According to the 2011 StatsSA Gender Statistics Report, across all four population groups, women (8.2% for all groups combined) are more likely than men (6.2%)<sup>2</sup> to have visited a health worker. This pattern is expected, as in addition to other health care-related needs, women tend to have more needs including reproductive health care, and health care related to pregnancy and childbearing.

The majority of South African women still rely a lot on health services that are provided by the state as evidenced by the percentage private medical scheme coverage and the numbers that are use private health facilities. Overall, South African women are less likely (38.8%) to visit private health facilities when they need health care than men (39.9%) and only 32.3% African women and men use private health facilities. Access to private medical scheme coverage is lowest at 9.3% for black African women compared to 70.7% for white women, 9.1% for black African men and 70.5% for white men.

#### ii. Reducing Impact of the HIV and AIDS Epidemic on Women

Women have borne the brunt of burden of HIV and AIDS epidemic disproportionately in society. Women remain at higher risk of HIV and are 1.6 times more likely than males to be HIV positive<sup>3</sup>. In 1990, less than 1% of pregnant women accessing public health services were found to be infected with HIV. By 2004, this figure had increased to 20% and currently the overall national HIV prevalence estimates among 15-49 year pregnant women have increased significantly from the 1990 figure and remain hovering at 29.5% in 2011 and 2012<sup>4</sup>. The total number of women between the ages of 15-49 years living with HIV has also increased from an estimated 16.7% in 2002 to 18.5% in 2014<sup>5</sup>, translating to approximately one-fifth of South African women in their reproductive ages being HIV positive. To address this problem, government through the South African National AIDS Council (SANAC) developed the National Strategic Plan on HIV and AIDS, sexually transmitted infections (STIs) and tuberculosis (TB) for 2007-2011 and for 2012-2017. This was undertaken through an extensive consultation process with a range of stakeholders in the health, education, mining, and transport sectors, trade unions, other government departments, research organisations and civil society organisations to prevent and mitigate the impact of HIV and TB.

Women make up 65% of the more than 20.2 million people that have to date been tested for HIV since 2010 through the HIV Counselling and Testing (HCT) campaign between April 2010 and June 2012. In addition, access to life saving anti-retroviral (ARV) treatment has improved the life expectancy for women. Statistics South Africa (Stats SA) estimates that the mid-year population of South Africa in 2014 to be at 54 million and approximately fifty-one per cent (51%) or approximately 27.64 million of the population is female. Life expectancy at birth is estimated at 59.1 years for males and 63.1 years for females in 2014. According to the 2014 midyear population estimates released by StatsSA, the life expectancy for women has increased from 55.7 in 2002 to 63.1 in 2014<sup>6</sup>.

There has also been a 60% reduction in mother-to-child transmission of HIV. Progress has been recorded in scaling up Prevention of Mother-to Child Transmission (PMTCT) of HIV from 71 per cent in 2009 to 96 per cent in 2012, resulting in reduction in peri-natal mother to child transmission from 8% in 2008 to 2.7% in 2011. This has improved the health and well-being of both mother and child.

#### iii. Improving maternal and child Health

The introduction of District Clinical Specialist Teams as part of Primary Health Care (PHC) Re-engineering has contributed to the reduction of maternal and infant mortality. The campaign on accelerated reduction of maternal and child mortality (CARMMA) has contributed in the reduction of deaths of mothers and infants. CARMMA focuses on promoting sexual and reproductive health services; antenatal care; access to skilled birth attendants; allocating dedicated obstetric ambulances and establishing maternity homes; strengthening human resources for maternal and child care; intensifying management of HIV positive mothers and children; promoting child survival through supporting exclusive breast-feeding, and provision of lactating mothers facilities in hospitals and promoting kangaroo mother care. Evidence also shows that as a result of these interventions, the maternal mortality rate (MMR) is steadily decreasing. In 1998 the MMR was standing at 150 per 100 000 and then increased sharply to 310 per 100 000 in 2008, and is now gradually declining to 269 per 100000 for population based figures and 149 per 100000 for facility based figures.

#### iv. Improving access to contraceptives and family planning

The ability of women to control their own fertility is fundamental to women's empowerment and equality. Reproductive rights—including the right to decide the number, timing and spacing of children, and to make decisions regarding reproduction free of discrimination, without coercion and violence, contribute to gender equality and empowerment. On improving access to contraception and family planning for women, government recently launched the National Family Planning Campaign in Tembisa in February 2014. This was undertaken as a partnership between the Departments of Health, Social Development and Economic Development and civil society, themed: *“My Responsibility, My Choice, Our Future- I choose dual protection”*. The aim of the campaign is to provide information and services about various methods that prevent HIV, STI's and unwanted pregnancies. The campaign encourages the use of a combination of condoms and a second method of protection. The sub-dermal implant which is a long acting progestogen- contraceptive method that is inserted under the skin in the upper arm was and providing protection from pregnancy for up to 3-5 years was also launched at the same time.

#### v. Choice of Termination of Pregnancy

The Choice on Termination of Pregnancy Act (Act No. 92 of 1996) has provided a legal framework for the provision of abortion services and has reduced the number of death occurring as a result of unsafe abortions by as much as 90 percent. However, despite reducing the number of illegal abortions by 90%, there are still serious challenges nationwide on the implementation of the Choice on Termination of Pregnancy Act as it has no impact on decreasing the rate of illegal abortions taking place in South Africa. Furthermore, the stigma associated with TOP's is common amongst health professionals who often reproach clients seeking TOP's, particularly if they are younger women. Women who need these services are often chastised by health professionals for being sexually active, for being 'irresponsible', and for choosing to terminate the pregnancy rather than give birth. Women seeking TOP's have on instances been turned away from public hospitals because the facility has reached its weekly abortion quotas or does not provide the service at all.

#### vi. The Human Papilloma Virus Vaccine Campaign

The human papillomavirus (HPV) is a major cause of cervical cancer and is responsible for the deaths of over 3 000 women in South Africa every year. Cervical cancer is the second most common cancer among women in South Africa and the National Cancer Registry reports that the highest rates can be found among black women aged 66 to 69 years of age. The launch of the Human Papilloma Virus (HPV) vaccine campaign in March 2014 is a major step towards protecting women against cervical cancer. The campaign targets girl-children aged between nine and 12 years old and aims is to vaccinate an estimated 500 000 girls in 17 000 schools. The HPV vaccine will contribute to reducing the number of women dying as a result of cervical cancer, although it will be of little use to those women who already have cancer of the cervix or have are sexually active.

#### vii. Sexual and Reproductive Rights for Youth

The health sector has prioritized sexual and reproductive health and rights (SRHR) for adolescent and youth to address their SRH needs. Girl-children in the adolescent phase have been found to experience the specific vulnerabilities that are unique to their age group namely: physiological vulnerability; high susceptibility to peer pressure; tendency to engage in risk-taking behaviour; less ability to negotiate safer sex practices; and difficulty accessing reproductive health information and services:

- a) With biologically and physiologically immature reproductive and immune systems, adolescent girls are particularly vulnerable to sexually transmitted infections (STIs)
- b) In addition, early pregnancy and STIs (including HIV) threaten the health of adolescent girl-children more than at any other age group. Adolescent females are further disadvantaged and made vulnerable by the differences in gender norms and pressure to engage in transactional sex for economic reasons. Young girls who are in relationships with significantly older men (intergenerational relationships) are also less likely to have negotiating power in the relationship.
- c) A final reason for investing in the SRHR of adolescents is that changing the behaviour of young people provides the greatest opportunity for intervening against STIs and AIDS by encouraging safer sexual behaviours in adolescents. Investing in the health of adolescents not only improves the health of adolescents today, but also ensures that the next generation of children is healthier.



#### **d) Violence against Women and Children**

South Africa faces an unparalleled problem of violence against women and children that affects all sectors of society irrespective of socio-economic status, ethnicity, age and religion. According to the South African Medical Research Council (MRC), the rates of homicide, rape, and childhood and domestic violence are significantly higher than those of countries of comparable level of development. Violence against women and children manifests either as emotional or physical abuse, murder including femicide, sexual abuse including rape and sexual violence on children. According to the MRC survey, in 2009 one woman was killed by a partner every eight hours in South Africa<sup>7</sup>.

Poverty, gender inequality and social inequity are key drivers of violence. Violence is often used to gain the sought after respect and power, whether through violent robbery, rape, severe punishment of children or violence against partners, domestic violence in the home, sexual abuse of girls in schools, sexual harassment at work, rape by husbands or strangers, “corrective rape” of lesbian women, and sexual abuse of vulnerable women such as migrants, refugees those with disabilities. Violence against women has other major detrimental and social impacts for women, and society. The MRC reports that young women who are HIV infected and have been exposed to intimate partner violence, are 50% more likely than other women to have contracted the HIV in the two years following the experience of violence.

Exposure to abuse of one’s mother is associated with the likelihood of becoming a victim (for women), and a perpetrator (by men) within an intimate partner relationship. Girls who are exposed to physical, sexual and emotional trauma as children are at increased risk of re-victimisation as adults. Exposure of boys to abuse, neglect or sexual violence in childhood greatly increases the chance of their being violent as adolescents and adults, and reduces their ability to form enduring emotional attachments. The abuse of alcohol and drugs is a key factor that contributes to violence against women and children. The very high per capita alcohol consumption in South Africa has resulted in acts of violence occurring after alcohol and drug abuse resulting in homicides and rape.

Violence against women and children has also placed an extra-ordinary burden on the over-burdened public health, legal and social systems. The impact of violence on health is seen in our health facilities, where an estimated 1.75 million people annually seek health care for injuries resulting from violence. The rape of women and children results in unwanted pregnancy, and the increased risk of contracting HIV and other sexually transmitted infections. Rape and domestic violence are both associated with the greatest number of Post Traumatic Stress Disorder (PTSD) cases. Over a third of women who have been violated develop PTSD which if untreated persists in the long term and depression, suicidal tendencies and substance abuse are common. Children who have been exposed to emotional, sexual and physical violence are at an increased risk of contracting HIV as well as suffering from depression, suicidal tendencies and even becoming substance abusers.

#### **e) Diseases of Lifestyle**

Diseases of lifestyle contribute at least 33% to the burden of diseases in South Africa. The South African National Health and Nutrition Examination Survey (SANHANES)<sup>8</sup> confirms that diseases of lifestyle are increasingly becoming a problem within the South African context. The lifestyle diseases manifest as Non-communicable diseases (NCD’s) as a result of high blood pressure, diabetes mellitus, cardiovascular diseases, obesity, cancer, respiratory diseases such as asthma, and mental health problems. NCDs are also increasingly posing a greater risk on the health and welfare of poor South Africans especially women. There are four key risk factors that have been identified namely: tobacco use, alcohol abuse, diet and physical activity. Low levels of physical activity affect 45.2% of women and 29.9% of males aggravating the prevalence of NCD’s. The incidence and prevalence of NCD’s accounted for 29% of all deaths in the country with cardiovascular deaths being a major cause of death. Over the next 10 years deaths due to NCDs are projected to increase by 24%. The lack of focused health promotion and prevention programmes and interventions, poor health seeking behaviour and the late detection of diseases are some of the major factors contributing to the high burden of NCDs.

#### **f) Social Determinants of Health**

Social determinants of health in South Africa consist of general socio-economic, cultural and environmental conditions; living and working conditions; social and community influences and individual lifestyle factors<sup>9</sup>. Factors such as poverty and underdevelopment, employment, access to basic services such as water, sanitation, electricity, fuel, housing, and provision of social security nets such as social grants have an impact on health outcomes and empowerment of women. Government has improved access to basic services through improving access to water, sanitation, electricity, roads and housing to a large extent which is important for good health.

Although access to water has been improved significantly, a minority of South Africans still do not have access to piped water inside their dwelling or on site. The proportion without such access fell sharply between 2001 and 2011, from 41.3% to 28.4%<sup>10</sup>. Although the percentage of households reliant on distant off-site water sources declined from 12% in 1999 to 6% in 2011, in instances where water must be collected outside the dwelling, female members of the household are twice as likely to male members of the household expected to travel at distances of a kilometre or more to collect water. The proportion of households with no toilet facilities has declined from 13.6% in 2001 to 8% in 2007<sup>11</sup>.

Access to fuel and electricity still affects women negatively. The percentage of black African households using wood and dung for cooking remains higher than for all other population groups in South Africa. In 2001, the percentage was 33.4% and this dropped to 20.8% in 2011<sup>12</sup>. Female members of the household are still twice as likely required to collect the fuel sources at distances of more kilometre or more away on any given day.

Poverty among women-headed households is higher than it is for the average household and women continue to earn less than men, even though differences in years of education have largely been narrowed. About 61 percent of women live in poverty, and 31 percent live in destitution, compared with 39 percent and 18 percent of men respectively<sup>13</sup>. Research shows that a smaller proportion of women than men are employed and a larger proportion of women than men are not economically active. Among both men and women, the percentage employed is highest for whites and lowest for black African women<sup>14</sup>. Women especially in rural areas are also more likely to be performing unpaid economic work and where they do not earn money from the work done. This includes activities where goods are produced for consumption within the household including subsistence agriculture. Improved health outcomes for women contribute to enhanced participation in productive economic activities thus contributing to sustainable economic development. Poor access to health care services and lack of income-earning opportunities, results in the feminization of poverty where lives of the women who in the majority earn poor wages or who perform unpaid economic work are being exposed to the daily struggle to simply survive.

#### **4. GAPS THAT STILL EXIST**

The government interventions addresses some of the issues elucidated in the Woman's Charter and Women's Charter for Effective Equality; the ANC Conference Resolutions on Gender and the ANC Women's League Resolutions on Health to improve health outcomes for women. However, gaps still exist in the areas pertaining to social determinants of health including on poverty reduction strategies, and access to health services especially for rural women.

It is evident that whilst the Constitution has outlawed unfair discrimination on the basis of gender, sexual orientation, and other considerations, the battle against patriarchy and advancing gender empowerment are still illusive dreams. These gaps identified contribute to women being subjected to inequities in health, thus adding to the persistence of poverty, access to basic services, and also weakening the battle against HIV/AIDS. A poorly accessible health care system also does not effectively prioritise sexual and reproductive health needs of women. Access to quality health has a bearing on improved health outcomes, but remains an elusive dream for women, most of whom are from rural settings and those still depending on inaccessible or poor quality health services in public health facilities. Furthermore lagging behind in participating fully in the economy contributes negatively to social determinants of health.

#### **5. WHAT NEEDS TO HAPPEN IN THE HEALTH SECTOR TO ACHIEVE RADICAL SOCIO-ECONOMIC TRANSFORMATION**

Good health is an important goal for sustainable development and is an indispensable prerequisite for poverty reduction, sustained economic growth and socio-economic development. The attainment of the highest possible level of health is also a most important world-wide social goal, whose realization requires not only the actions of the health sector, but many other sectors such as social and economic clusters. Good health is important for gender empowerment and socio-economic development. It is well known that the critical aspect of promoting gender equality is the empowerment of women, with a focus on identifying and redressing power imbalances and giving women more autonomy to manage their own lives. Women's empowerment is also vital to sustainable development and the realization of human rights.

The radical socio-economic transformation should integrate gender equality and women's empowerment into poverty reduction, democratic governance, crisis prevention and recovery, and environment and sustainable development. The empowerment of women through full participation in economic life across all sectors including the health sector is essential to building stronger economies; achieving internationally agreed goals for development and sustainability such as the Millennium Development Goals (MDG's), and improve the quality of life for women, their families and communities. Women therefore should not just be recipients and beneficiaries of services delivered through the health sector, but should also be actively involved in the production of these health services.

**a) Opportunities for economic participation in the production of health services that can contribute to radical socio-economic transformation for women**

- i. Pharmaceuticals that also includes research and development of indigenous knowledge systems
- ii. Health is a woman-intensive sector and protective clothing as well as uniforms for the medical and nursing profession and other allied professions should be prioritized for women
- iii. Production of hospital linen including theatre linen
- iv. Food services
- v. Cleaning services and Horticulture
- vi. Employment opportunities through health promotion and disease prevention using expansion of Community Health Workers platform through PHC Re-engineering.
- vii. Training and mentorship / leadership development
- viii. Research and development especially for local production of Medical Equipment and Health Technology through CSIR and Universities.
- ix. Health infrastructure/Health Estate to improve access to health services
- x. Further improve access to reproductive health services

**b) Strategies that can be adopted by the health sector to empower women to achieve radical socio-economic transformation include:**

- i. Procurement of hospital linen and uniform through cooperatives established by women especially in rural areas
- ii. Procurement of vegetables and food products through rural women cooperatives
- iii. Management and mentorship programmes for young professional women working in the health sector
- iv. Indigenous knowledge systems are usually in the hands of rural women and in commercializing these systems, bias should be given to women for the intellectual property rights
- v. Other interventions that will address social determinants of health such as rural development projects and Public Work Programmes to improve access to water, housing and sanitation for rural communities
- vi. Participation in activities that will contribute to reversal of future climate change scenarios thus reducing the likelihood of resurgence of infectious diseases such as malaria, water-borne diseases such as cholera, typhoid etc.

(Endnotes)

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