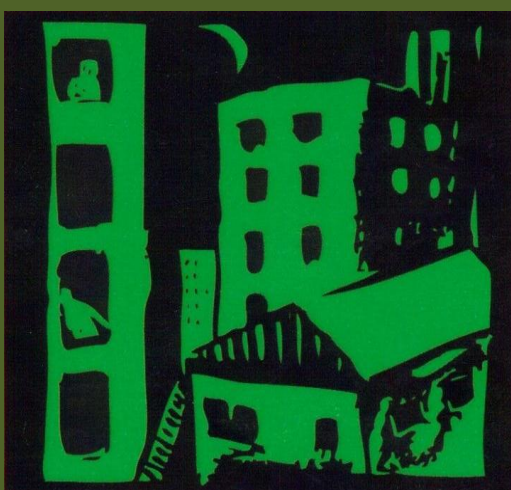


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# Geography, marginalisation and the performance of the right to have access to health care services in Johannesburg

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## 1 INTRODUCTION

Legal human rights discourse is often criticised for its abstract and procedural nature which, as the Critical Legal Studies scholars of the 1980s famously argued, distances rights from the real lived experiences of their beneficiaries.<sup>1</sup>

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<sup>1</sup> See Gabel P "The phenomenology of rights-consciousness and the pact of the withdrawn selves" (1984) 62 *Texas Law Review* 1563 at 1576-77, 1583-84 and 1588-90; Tushnet M "An essay on rights" (1984) 62 *Texas Law Review* 1363 at 1364, 1370-75, 1379-80 and 12382-83. For application of these arguments in relation to contemporary South African socio-economic rights discourse, see Pieterse M "Eating socioeconomic rights: the usefulness of rights talk in alleviating social hardship revisited" (2007) 29 *Human Rights Quarterly* 796.

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These lived experiences of rights are contextual and placebound, and involve a myriad of actions and interactions by and between state agencies, rights-beneficiaries and their fellow citizens. To understand the intricacies of the enjoyment and infringement of particular rights in particular places and contexts, attention must be paid to *where, how* and *by or with whom* rights are actualised.<sup>2</sup> Rights have strong geographical, performative and relational elements, which are often overlooked by State agencies tasked with their fulfilment, as well as by legal scholars and processes concerned with their protection and enforcement.

This article aims to strengthen the theoretical case for geographical awareness in human rights work, by considering the performance of the right to have access to health care services in section 27(1)(a) of the 1996 Constitution, by particular inhabitants of Johannesburg. It shows how a “performative” understanding of the right to have access to health care services dovetails with the international law approach to assessing compliance with the right to health, and points to certain features of South African socio-economic rights jurisprudence that enable such an understanding of the right.

Thereafter, the article considers some of the geographic aspects of access to health care services in Johannesburg, with a particular focus on the experiences of marginalised groups. Current health system reforms and urban development initiatives in Johannesburg, that relate to the geographical features of access to health care in the city, are then assessed. It is shown that, while many of these measures will have very positive consequences for the progressive realisation of the right to have access to health care services, the interaction of geographic factors with other determinants of access (notably, affordability and quality of care, as well as stigmatisation of certain care seekers) may nevertheless continue to frustrate access to care by marginalised groups.

To show that this is not inevitable, two examples of target group specific, place-aware interventions pertaining to access to sexual health services by marginalised groups in the city are discussed. The article ultimately suggests that geographical and related factors which impact on the physical performance of rights must be taken into account when legislative and policy measures aimed at their progressive realisation are conceptualised and implemented, as well as when the State’s compliance with its corresponding positive constitutional obligations is assessed. Some cautionary notes for law and policy reform, particularly in relation to the rolling out of National Health Insurance, are offered accordingly.

## **2 "ACCESS" TO HEALTH CARE SERVICES, GEOGRAPHIC ACCESSIBILITY AND THE PERFORMANCE OF SOCIO-ECONOMIC RIGHTS IN AN URBAN SETTING**

For the most part, people do not simply receive the objects of their socio-economic

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<sup>2</sup> See Connolly Carmalt J "Rights and place: using geography in human rights work" (2007) 29 *Human Rights Quarterly* 68 at 70; Jones P & Chingore N "Health rights: politics, places, and the need for 'sites for rights'" in Langford M, Cousins B, Dugard J & Madlingozi T (eds) *Socio-economic rights in South Africa: symbols or substance?* (Cambridge: Cambridge University Press 2014) 226 at 235-36; Malan N "Rights, the public and the South African Constitution: Civil society and the performance of rights" (2008) 31 *Anthropology SA* 58 at 63; Pieterse M "Relational socio-economic rights" (2009) 25 *SAJHR* 198 at 199.

rights from the State. Instead, they (attempt to) use or acquire these objects, when and to the extent that they need them, through a range of actions and interactions, not all (or any) of which necessarily involve the State or its agencies. In order to grasp the extent of the enjoyment of socio-economic rights by particular people in particular places and contexts, attention should thus be paid to the *actions* through which they endeavour to realise their socio-economic rights for themselves.<sup>3</sup> Such actions will inevitably be shaped by the physical and other characteristics of the spaces in which they are performed.

In addition to place, such a “performative” conception of socio-economic rights (i.e. one that focuses on the performance of physical actions endeavouring to realise the rights) draws attention to individual autonomy and capabilities, and thereby emphasises those structural and peculiarly personal features of individual lives which prevent people from exercising their rights optimally.<sup>4</sup> As such, it emphasises the horizontal dimensions and relational nature of rights (which, for many, tend to be exercised through a range of private contractual or personal relationships with others)<sup>5</sup> as well as their interdependence. Focusing on the performance of a particular socio-economic right could therefore, for instance, reveal shortcomings in the enjoyment of the rights to substantive equality, freedom of movement, or personal autonomy.

A performative conception of the right to access health care services is easy to reconcile with the dominant understanding of the right to health in international law. In its General Comment on the right to health enshrined in article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR), the United Nations Committee on Economic, Social and Cultural Rights (UNCESCR) proposed that achievement of the right to health ought to be measured with reference to four “interrelated and essential terms”, namely the availability, accessibility, acceptability and quality of health care goods and services. The standard of availability requires that relevant health care goods and services exist and are available in sufficient quantities within domestic health systems. More directly relevant for present purposes, the standard of accessibility demands that health care facilities, goods and services be within patients’ geographic reach and that they are physically accessible, as well as affordable. In terms of the standard of acceptability, health care facilities, goods and services must be delivered in a manner that is both ethically sound and culturally and personally acceptable to patients. Finally, medical treatment must comply with relevant scientific and clinical standards and must be of adequate quality.<sup>6</sup> As will be illustrated

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<sup>3</sup> Malan (2008) at 63; Malan N “The performance of the right to have access to social security” (2009) 13 *Law, Democracy & Development* 71 at 75-7, 81 and 90-2; Pieterse (2009) at 201 and 205.

<sup>4</sup> Malan (2008) at 63; Malan (2009) at 75-6. On the centrality of autonomy for the performance of the right to health and its interaction with material conditions, see further Pieterse M “The interdependence of rights to health and autonomy in South Africa” (2008) 125 *SALJ* 553 at 555 and 564.

<sup>5</sup> Malan (2008) at 61-4; Malan (2009) at 76, 79 and 82-4; Pieterse (2009) at 199, 201, 205 and 207.

<sup>6</sup> UNCESCR General Comment 14 *The right to the highest attainable standard of health (article 12 of the International Covenant on Economic, Social and Cultural Rights)* (2000) at para 12. See further Chapman AR “Core obligations related to the right to health and their relevance for South Africa” in Brand D & Russell S (eds) *Exploring the core content of socio-economic rights: South African and international perspectives* (Pretoria: Protea 2002) 35 at 45; Pieterse M *Can rights cure? The impact of human rights*

in part 3 below, emphasising the performative dimensions of the right to health highlights a number of essential linkages between these standards.

Rather than a broad “right to health”, section 27(1)(a) of the South African Constitution enshrines a narrower right to “*have access to health care services*”. A notable departure from the international law formulation of the right to health is section 27’s inclusion of the notion/standard of “access”. Whereas commentators initially understood this simply to imply that the Constitution does not envisage direct provision of health care goods and services at State expense,<sup>7</sup> it is increasingly accepted that the notion of “access” lends a particular physical and geographical dimension to the right to health care.<sup>8</sup> Over and above providing an entry point for the international law standards of availability, accessibility, acceptability and quality of care into interpretations of section 27(1)(a),<sup>9</sup> the “access” standard therefore allows for the right to be understood performatively, by conceiving its content, as well as the State’s obligations towards beneficiaries, with reference to the ways in which they endeavor to realise it for themselves.<sup>10</sup>

While the Constitutional Court has decided a fair number of socio-economic rights cases to date, the seminal case of *Grootboom*<sup>11</sup> (an access to housing case best known for the Court’s formulation of its “reasonableness” standard for assessing compliance with the State’s positive constitutional obligations in terms of socio-economic rights) remains the only judgment in which it specifically paid attention to the meaning of the notion of “access” in the Constitution. The Court held that the “access” standard required socio-economic rights to be viewed as interdependent and mutually supportive and that, in accordance with the standard of “progressive realisation”, the notion of “access” indicated that the State should enable and empower people to realise their socio-economic rights for themselves, rather than to directly provide them with specific goods and services. Except in relation to society’s most vulnerable and destitute members (in relation to whom, in certain circumstances, direct provision of goods and services would be appropriate and necessary), the Court felt that the State’s socio-economic obligations to citizens would mostly entail removing obstacles to the enjoyment of socio-economic rights, “unlocking the system” so as to enable such

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*litigation on South Africa’s health system* (Pretoria: PULP 2014) at 13; Toebes B *The right to health as a human right in international law* (Amsterdam: Hart/Intersentia 1999) at 287-88.

<sup>7</sup> See, for instance, De Vos P “Pious wishes or directly enforceable human rights? Social and economic rights in South Africa’s 1996 Constitution” (1997) 13 *SAJHR* 67 at 87; Gabriel A “Socio-economic rights in the Bill of Rights: comparative lessons from India” (1997) 1(6) *Human Rights and Constitutional Law Journal of South Africa* 8 at 9; Heyns C & Brand D “Introduction to socio-economic rights in the South African Constitution” (1998) 2 *Law, Democracy & Development* 153 at 159.

<sup>8</sup> Connolly Carmalt (2007) at 69; Malan (2009) at 81 and 87.

<sup>9</sup> See Pieterse M “Resuscitating socio-economic rights: constitutional entitlements to health care services” (2006) 22 *SAJHR* 473 at 480; 495 and authorities there cited. In terms of s 39(1)(b) of the Constitution, international law must be considered when courts interpret corresponding domestic constitutional rights.

<sup>10</sup> Malan (2008) at 59 and 62-3; Malan (2009) at 81, 83-4 and 88-9.

<sup>11</sup> *Government of the Republic of South Africa & Others v Grootboom & Others* 2001 (1) SA 46 (CC).

enjoyment and facilitating access to the objects of the rights.<sup>12</sup>

This understanding of “access” explains the Constitutional Court’s widely lamented resistance, in adjudicating socio-economic rights cases, to the notion of State provision of social goods and services on demand. In relation to access to health care services, this reluctance was most famously expressed in the *Treatment Action Campaign* case, where the Court emphasised that its finding that the government’s restriction of the availability of the drug Nevirapine to a limited number of public hospitals was unreasonable and accordingly unconstitutional, did not mean that everyone could immediately claim access to the drug.<sup>13</sup> But the notion of access set out in *Grootboom* also squares well with a performative understanding of socio-economic rights, including the right of access to health care services.<sup>14</sup>

Indeed, while not elaborating on *Grootboom*’s understanding of the concept, the Constitutional Court’s subsequent socio-economic rights jurisprudence has on occasion displayed an appreciation of the notion’s geographical and performative dimensions. For instance, in *New Clicks South Africa*, which concerned the introduction of price capping regulations for retail pharmacies, several members of the Court warned that measures aimed at enhancing access to health care through increasing affordability of medicines would not pass constitutional muster where their effect was to make medicines unavailable and inaccessible in certain areas, by driving rural or courier pharmacies out of business.<sup>15</sup> Further, in *Residents of Joe Slovo Community*, the Court regarded geographic proximity to hospitals and clinics, as well as to schools and other social services, as a factor impacting on the reasonableness of housing policy and the adequacy of housing. It accordingly ordered that a large-scale relocation of inhabitants of a Cape Town informal settlement could only proceed if, among other requirements, transport to such amenities was provided.<sup>16</sup>

A number of High Court judgments pertaining to the right of access to education in section 29 of the Constitution have shown similar appreciation of the geographical dimensions of socio-economic rights. In *Tripartite Steering Committee*, for instance, the Eastern Cape High Court held that a lack of transport to schools in rural areas rendered the right of access to basic education illusory. The Court proceeded to conclude that, “in instances where scholars’ access to schools is hindered by distance and inability to afford the costs of transport, the State is obliged to provide transport to them in order

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<sup>12</sup> At paras 35-6.

<sup>13</sup> *Minister of Health & Others v Treatment Action Campaign & Others (No 2)* 2002 (5) SA 721 (CC) at para 125. For criticism of the Court’s resistance to a more benefit centred approach, see Pieterse (2006) at 486-90.

<sup>14</sup> Malan (2009) at 88. See also Coggin T & Pieterse M “A right to transport? Moving towards a rights-based approach to mobility in the city” (2015) 31 *SAJHR* 294 at 303.

<sup>15</sup> *Minister of Health & Another v New Clicks South Africa (Pty) Ltd & Others* 2006 (2) SA 311 (CC) at paras 19 (per the entire Court), 404 (per Chaskalson CJ), 526-27, 557-63 (per Ngcobo J), 654-55 (per Sachs J), 714, 772 and 781 (per Moseneke J). For discussion, see Pieterse (2014) at 72.

<sup>16</sup> *Residents of Joe Slovo Community, Western Cape v Thubelisha Homes & Others* 2010 (3) SA 454 (CC) at paras 7 (Court’s order), 107 (per Yacoob J), 254-55 (per Ngcobo J) and 321-22 (per O’Regan J). For discussion, see Coggin & Pieterse (2015) at 305.

to meet its obligations ... to promote and fulfill the right to basic education".<sup>17</sup> Similarly, in *Legoale*, a settlement agreement in terms of which learners whose school was closed down were to be provided with a bus service to the distant site of a new school, was made an order of court.<sup>18</sup>

The judgments discussed above suggest that courts may well find that it amounts to a breach of the right to have access to health care services where such services do not physically exist within a reasonable distance from where people find themselves, or where relevant facilities are unreachable, for instance, due to a lack of transport. Commentators have accordingly pointed to rural/urban discrepancies in access to health care services and the relative unavailability or inaccessibility of such services in rural areas as constitutionally suspect instances of unequal enjoyment of the right to have access to health care services.<sup>19</sup> Moreover, the Constitutional Court's approach to reasonableness in *New Clicks South Africa* and *Residents of Joe Slovo Community* suggests that laws and policies which regulate access to health care may be found to be unreasonable (and, hence, potentially unconstitutional) when they fail to enable or facilitate the physical performance of the right to have access to health care services.

In this article the focus is on geographical and performance-related hurdles to accessing health care services within urban areas and, more specifically, within a single city. In this respect, a performative approach to the right of access to health care services must also be cognisant of theory on the so-called "right to the city", a concept made famous by French sociologist Henri Lefebvre, who regarded it as a "cry and a demand" by poor and marginalised urban communities to be included in the urban fabric. This "right" is physically enacted rather than legally asserted, through the production of urban space by urban inhabitants' actions of everyday life. It consists of a myriad competing and interacting claims by urban dwellers to inhabit, appropriate and participate in the city and aims, among other things, to ultimately render the city more inclusive.<sup>20</sup> Inhabitants' physical movements in and around the city, as well as the ways

<sup>17</sup> *Tripartite Steering Committee & Another v Minister of Basic Education & Others* 2015 (5) SA 107 (ECG) at para 19. See also paras 12-18.

<sup>18</sup> *Legoale v Minister of Education, North West* (NWHC) unreported case no 499/2011. For discussion, see Coggin & Pieterse (2015) at 304; Skelton A "The role of the courts in ensuring the right to a basic education in a democratic South Africa: a critical evaluation of the case law" (2013) 46 *De Jure* 1 at 11-13.

<sup>19</sup> See, for example, Harris B, Gouge J, Ataguba JE, McIntyre D, Nxumalo N, Jikwana S & Chersich M "Inequities in access to health care in South Africa" (2011) 32 (Suppl) *Journal of Public Health Policy* S102 at S103 and S118; Ngwena C "Accessing abortion services under the Choice on Termination of Pregnancy Act: realising substantive equality" (2000) 25 *Journal for Juridical Science* 19 at 33-35; Pieterse (2014) at 41; South African Human Rights Commission (SAHRC) Report *Public inquiry: access to health care services* (2007) at 48.

<sup>20</sup> Lefebvre H *Le droit a la ville* (1968), translated and reprinted as part of Lefebvre H ((Kofman E & Lebas E - trans) *Writings on Cities* (Oxford: Blackwell 1996) at 101-03, 158-59 and 173-74. For contemporary appropriation of this theory in relation to various aspects of socio-economic rights and urban social justice see, for instance, Coggin T & Pieterse M "Rights and the city: an exploration of the interaction between socio-economic rights and the city" (2012) 23 *Urban Forum* 257; Fernandes E "Constructing the 'right to the city' in Brazil" (2007) 16 *Social & Legal Studies* 201; Harvey D "The right to the city" (2008) 53 *New Left Review* 23; Marcuse P "From critical urban theory to the right to the city" (2009) 13 *City* 185 at 190-93; Mitchell D *The right to the city: social justice and the fight for public space* (New York: Guilford Press 2003); Purcell M "Excavating Lefebvre: the right to the city and its urban politics of the inhabitant" (2002) 58 *GeoJournal* 99.

in which they access its amenities and participate in its processes, may be viewed as performative expressions of the right.<sup>21</sup>

Since health is at once a good to be accessed in the city (in the form of health care services), a consequence of the enjoyment of various features of the right to the city and a capacity that enables the exercise of other elements of the right, there have been calls for increased articulation between understandings of the right to health and the right to the city, especially when it comes to the spatial dynamics of access to health care services in urban areas.<sup>22</sup> While the many complexities of the right to the city are beyond the scope of this article, it is important to understand how the shape and form of the city impacts on urban inhabitants' health and health-seeking behaviour, whilst not losing sight of how the performance of the right of access to health care services in turn contributes to shaping life in the city.

### 3 ACCESSING HEALTH CARE IN JOHANNESBURG

#### 3.1 Introducing Johannesburg<sup>23</sup>

Established as a mining camp in the 1890s and growing rapidly ever since, Johannesburg is South Africa's largest city (with its population currently estimated to be in the region of 4.5 million<sup>24</sup>) and its undisputed economic capital. It is arguably also the most diverse, complex, contested and vibrant city in the country and is home not only to South Africans from all races<sup>25</sup> and walks of life but also to a great number of trans-border migrants from the southern African region. Much of its growth in recent years has been due to such migration, as well as to the well-documented effects of urbanisation, with a great many people from rural areas continuing to move to the city for economic opportunity.

As with all other major South African towns and cities, Johannesburg's vast

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<sup>21</sup> Coggin & Pieterse (2015) at 298.

<sup>22</sup> See Skinner E & Masuda JR "Right to a healthy city? Examining the relationship between urban space and health inequity by Aboriginal youth artist-activists in Winnipeg" (2013) 91 *Social Science & Medicine* 210 at 211-12.

<sup>23</sup> It is impossible to do justice to the history and complexities of such a vast and contrast-filled city as Johannesburg, in a few paragraphs. For far more detailed attempts (which, in addition to the sources cited specifically in the remainder of this part, were used as general sources to inform the overview presented here), see Beall J, Crankshaw O & Parnell S *Uniting a divided city: governance and social exclusion in Johannesburg* (London: Earthscan 2002); Murray MJ *Taming the disorderly city: the spatial landscape of Johannesburg after apartheid* (London: Cornell University Press 2008); Murray MJ *City of extremes: the spatial politics of Johannesburg* (Durham: Duke University Press 2011); Tomlinson R, Beauregard RA, Bremner L & Mangcu X "The postapartheid struggle for an integrated Johannesburg" in Tomlinson R, Beauregard RA, Bremner L & Mangcu X (eds) *Emerging Johannesburg: perspectives on the post-apartheid city* (New York: Routledge 2003) 3.

<sup>24</sup> See Statistics South Africa "City of Johannesburg" statistics available at <[http://beta2.statssa.gov.za/?page\\_id=1021&id=city-of-johannesburg-municipality](http://beta2.statssa.gov.za/?page_id=1021&id=city-of-johannesburg-municipality)> (accessed 24 June 2016); South African Cities Network *State of South African cities report* (2016) at 343.

<sup>25</sup> An estimated 76.4% of Johannesburg's population are Black (African); 12.3% are White; 5.6% Coloured and 4.9% Indian or Asian: Statistics SA (2016).

spatial landscape was profoundly shaped by the racial segregation of apartheid.<sup>26</sup> Comparatively overcrowded and under-serviced townships for Black, Coloured and Indian residents were established on the far outskirts of the city (most notably, Soweto, Eldorado Park and Lenasia in the South-West), whereas the central business district and its surrounding (well developed and well serviced) suburbs in all directions were reserved for White inhabitants. With the notable exception of Alexandra in the north (which ended up being very well situated in terms of economic opportunity, being a stone's throw away from Sandton, which was to develop into the city's prime business hub) these were all economically and spatially severed from the city, by distance as well as by a relative paucity of road links and public transport networks.<sup>27</sup> This contributed directly to the marginalisation and impoverishment of many of their residents.

Racial segregation in Johannesburg was spatially resisted from the beginning, but this gained momentum from the 1970s onwards, when people of different races began moving into the inner city flatlands of Hillbrow, Joubert Park, Berea and Yeoville, and into "inner" suburbs, such as Fordsburg, Mayfair and Troyeville, in defiance of Group Areas legislation.<sup>28</sup> Since the formal crumbling of the apartheid State in the early 1990s, the middle and upper class northern suburbs have gradually de-racialised (though their population remains disproportionately White), whereas the inner-city and its surrounding flatlands have seen capital and middle class (White) flight (predominantly to the northern suburbs)<sup>29</sup> and are now mostly home to poorer, Black residents. Unsurprisingly, the racial and socio-economic makeup of outlying townships has for the most part not changed, though many better off erstwhile township residents have moved into Johannesburg's (traditionally working class) southern suburbs.

Apart from the urban poor, dilapidated and decayed spaces in the inner city and surrounding flatlands are home also to a great many marginalised residents, including so-called "illegal" foreign migrants (for whom Hillbrow and Yeoville, especially, are ports of entry into the city) as well as persons whose lives and livelihoods are otherwise illegal and stigmatised, such as criminals, drug dealers and addicts, and sex workers.<sup>30</sup> This is no coincidence – in cities all over the world a combination of law and law

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<sup>26</sup> For common trends across South African cities in this regard, see Davies RJ "The spatial formation of the South African city" (1981) (supp 2) *GeoJournal* 59.

<sup>27</sup> On the role of spatial and transport planning in this marginalisation see Czegledy AP "Getting around town: transportation and the built environment in post-apartheid South Africa" (2004) 16 *City & Society* 63 at 65-7.

<sup>28</sup> See Beavon K *Johannesburg: The making and shaping of the city* (Pretoria: UNISA Press 2004) at 216-17; Morris A *Bleakness & light: inner-city transition in Hillbrow, Johannesburg* (Johannesburg: Wits University Press 1999) at 9-20.

<sup>29</sup> For some of the dynamics of this exodus, as well as of middle class life and space in the northern suburbs, see Czegledy AP "Villas of the highveld: a cultural perspective on Johannesburg and its northern suburbs" in Tomlinson et al (eds) (2003) 21.

<sup>30</sup> See Beavon (2004) at 222-24; Dinath Y "Between fixity and flux: grappling with transience and permanence in the inner city" in Harrison P, Gotz G, Todes A & Wray C (eds) *Changing space, changing city: Johannesburg after apartheid* (Johannesburg: Wits University Press 2014) 232 at 236; Grant R & Thompson D "City on edge: immigrant businesses and the right to urban space in inner-city Johannesburg" (2015) 36 *Urban Geography* 181 at 183; Landau LB "Transplants and transients: idioms of belonging and dislocation in inner-city Johannesburg" (2006) 49(2) *African Studies Review* 125 at 126 and 130; Morris (1999) at 57 and 61-8; Murray (2008) at 159; Murray (2011) at 150-52.



enforcement, urban management, market forces and social pressures have the effect of relegating marginalised persons to marginalised space.<sup>31</sup> In these spaces, existing health and social vulnerabilities are typically exacerbated by poor and overcrowded living conditions, exposure to violence and lack of legal protection.<sup>32</sup>

The fairly large scale regeneration of Johannesburg's inner city and immediate surrounding areas in recent years has seen heavily contested and well documented displacement of poor and marginalised residents from formerly abandoned or neglected buildings which they had (often illegally) occupied in the wake of the "emptying out" of the inner city in the mid-1990s.<sup>33</sup> While this regeneration continues to gain pace, many of today's poor and marginalised inner city residents continue to live in such "hidden spaces",<sup>34</sup> though the effect of regeneration has been that competition for such space has become increasingly fierce. The city further has a discernible homeless community who seek shelter under bridges and in public space in and around the downtown area.

Johannesburg further boasts a substantial number of ever-growing informal settlements on the urban periphery, which tend to be the place of settlement for a great number of the city's new arrivals from rural areas (who are typically also the city's poorest and least educated residents, and are also the most likely to be unemployed).<sup>35</sup> These settlements are Johannesburg's most destitute, least connected and most unhealthy environments, and exhibit a discernably greater burden of disease than other areas (including, pertinently, the highest incidence of HIV infection in the city).<sup>36</sup>

Overall, then, just as in most big cities around the world, Johannesburg's poorest and most socially vulnerable residents tend to live in its least healthy and least connected areas. In Johannesburg, though, this is exacerbated by such disconnectedness having been purposefully designed into the urban fabric. While much has been done in the last 20 years to "re-stitch" the fragmented city, it remains one where different people live in spaces which are, quite literally, worlds apart. Moreover, a legacy of

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<sup>31</sup> Dinath (2014) at 238-39; Grant & Thompson (2015) at 184; Murray (2011) at 150-53 and 279-82; Pieterse M "Law, rights, space and sexual citizenship in South Africa" (2015) 41 *Social Dynamics* 482 at 485; Veary J "Hidden spaces and urban health: exploring the tactics of rural migrants navigating the city of gold" (2010) 21 *Urban Forum* 37 at 40-43.

<sup>32</sup> See Veary J "Migration, urban health and inequality in Johannesburg" in Bastia T (ed) *Migration and inequality* (London: Routledge 2013) 121 at 121 and 138; Walls HL, Veary J, Modisenyane M, Chetty-Makan CM, Charlambous S, Smith RD & Hanefeld J "Understanding healthcare and population mobility in southern Africa: the case of South Africa" (2016) 106(1) *SA Medical Journal* 14.

<sup>33</sup> These struggles, many of which culminated in court action, are beyond the scope of this article. For thorough accounts see, for instance, Centre on Housing Rights and Evictions *Any room for the poor? forced evictions in Johannesburg, South Africa* (2005) at 41-74; Wilson S "Litigating housing rights in Johannesburg's inner city: 2004-2008" (2011) 27 *SAJHR* 127.

<sup>34</sup> For an account of life in some of these spaces immediately to the south-east of the inner city, see Veary (2010).

<sup>35</sup> See Veary J, Palmary I, Thomas L, Nunez L & Drimie S "Urban health in Johannesburg: the importance of place in understanding intra-urban inequalities in a context of migration and HIV" (2010) 18 *Health & Place* 694 at 697; Veary (2013) at 127-28.

<sup>36</sup> Thomas E "HIV/AIDS: implications for local governance, housing and the delivery of services" in Tomlinson et al (eds) (2003) 185 at 188; Veary et al (2010) at 699; Veary (2013) at 132.

inadequate public transport has spawned a car dependent culture, with the result that “getting around town for the poor majority is ... often difficult without a personal vehicle that can quickly circumvent the obstacles that have been literally designed into the urban fabric and remain in place”.<sup>37</sup> For many of Johannesburg’s most needy residents, then, the act of accessing social services can be cumbersome and complex, as will now be illustrated.

### 3.2 Health care services and health seeking behaviour in Johannesburg

Being South Africa’s major urban centre, Johannesburg boasts a large number of public hospitals and primary health care clinics which, while more densely distributed towards the centre of town, do service the entirety of its (formal) geography.<sup>38</sup> As will be elaborated below, the Municipal Council is steadily increasing the number of clinics across the city, in a drive to ensure that no resident should have to travel more than five kilometers to a primary health care facility. In addition to these State run facilities, Johannesburg contains the highest number of hi-tech, private health care facilities in South Africa,<sup>39</sup> while a number of NGO or church run, non-profit health services are also rendered in the inner city area. Moreover, there are medicine dispensaries or pharmacies linked to many hospitals and clinics, and private retail pharmacies (many with extended opening hours) are well distributed across the city.<sup>40</sup> Availability of health care, in and of itself, is thus not an issue in Johannesburg.

Accessibility, however, is sometimes a different issue. Wealthy and middle class residents who can afford private care (either themselves or through health insurance) and who own private motor vehicles can access care fairly conveniently. They accordingly tend to shop around for the most acceptable and best quality care on offer, even where this means travelling some distance.<sup>41</sup> However, the same is not true for the less well-off and more geographically isolated residents, many of whom use public transport, or walk, to access health care. For these residents, for many of whom money and time are both limited resources, transport costs and time wasted in attempting to physically access care (through having to walk to public transport points, wait for transport, walk again to points of health care service delivery, and then queue, often for

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<sup>37</sup> Czegledy (2004) at 67. See also Coggin & Pieterse (2015) at 295-96; Veary et al (2010) at 694-95 and 699-700.

<sup>38</sup> For figures on and analysis of the supply of public hospitals nationwide, in terms of which Gauteng Province is adequately serviced, especially in relation to tertiary care, see Heunis JC & Janse van Rensburg AP “Hospitals and hospital reform in South Africa” in van Rensburg HCJ (ed) *Health and health care in South Africa* (Pretoria: Van Schaik 2ed 2012) 535 at 551-54. For visual maps of clinic and pharmacy distribution across Gauteng and Johannesburg see Helen Suzman Foundation *Pharmaceuticals in South Africa – an enquiry* (2015) at 75 and 77. For a list of Johannesburg’s public hospitals and clinics, see <[http://www.joburg.org.za/index.php?option=com\\_content&task=view&id=43&Itemid=168](http://www.joburg.org.za/index.php?option=com_content&task=view&id=43&Itemid=168)> (accessed 24 June 2016).

<sup>39</sup> More than half of all private health care facilities in South Africa are located in Gauteng Province. See Heunis & Van Rensburg (2012) at 558-59.

<sup>40</sup> According to a recent study there is near optimal distribution of pharmacies across the city: see Helen Suzman Foundation (2015) at 66-7.

<sup>41</sup> See Harris et al (2011) at S112.

several hours, for consultations and dispensaries<sup>42</sup>) often constitute substantial hurdles to accessing care.<sup>43</sup>

These frustrations are compounded when patients (whose mobility is often hampered by the fact of their illness or injury<sup>44</sup>) are referred for further (secondary or tertiary) care at different institutions, particularly since State provided transport between referral hospitals was discontinued due to cost constraints some years ago. In a report pertaining to rights violations in the health sector, the South African Human Rights Commission has flagged this lack of inter-facility transport, together with sub-optimal ambulance services, as constituting significant barriers to accessing advanced health care in the public sector.<sup>45</sup>

Moreover, in many respects the performance of accessing health care is not completed by simply presenting at a health care institution. Different health facilities offer different services and have different entry requirements, meaning that patients cannot always be served at nearby facilities and are sometimes turned away when they do present for care. Examples here range from private facilities declining to consult patients who are not medically insured and cannot pay for treatment up-front, to facilities not offering the kind of treatment requested (such as tertiary facilities only accepting patients on referral), to institutions refusing access to foreign migrants who do not possess required identity documentation.<sup>46</sup> Over and above constituting a hurdle to access in and of itself, bureaucracy thus often frustrates accessing care by adding waiting and travelling time to the performance.

The picture becomes even more complicated when accessibility is viewed in tandem with quality and acceptability of care. People tend to avoid making use of health care services where they perceive the services to be of poor quality, or where their experiences of accessing care at particular locations have been negative in the past. Research has shown that, depending on the kind of health service required, patients attempt to reach those facilities where they believe they would receive the best or most appropriate care, or where their experience of accessing it would be least cumbersome or most positive, even where this requires having to cover significantly larger distances.<sup>47</sup> Many Soweto residents, for instance, choose to make their way into town to access care, because they are not prepared to deal with the long waiting times and

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<sup>42</sup> For vivid descriptions of some of these journeys see Le Marcis F “The suffering body of the city” in Nuttall S & Mbembe A (eds) *Johannesburg: the elusive metropolis* (Johannesburg: Wits University Press 2008) 170 at 172-75.

<sup>43</sup> See for instance Harris et al (2011) at S112; SAHRC (2007) at 41-2; Veary J “Migration, access to ART, and survivalist livelihood strategies in Johannesburg” (2008) 7(3) *African Journal of AIDS Research* 361 at 368.

<sup>44</sup> For accounts, see Le Marcis (2008) at 171.

<sup>45</sup> SAHRC (2007) at 42. See also Coggin & Pieterse (2015) at 304.

<sup>46</sup> While official Department of Health policy is that lack of documentation should not be a barrier to access to health services in the public sector, different institutions insist on different forms of documentation as admission requirements in practice. See Veary (2008) at 367-69, also Landau LB “Protection and dignity in Johannesburg: shortcomings of South Africa’s urban refugee policy” (2006) 19 *Journal of Refugee Studies* 308 at 320.

<sup>47</sup> Le Marcis (2008) at 176-77.

queues at Chris Hani Baragwanath hospital.<sup>48</sup> Where optimal care is physically inaccessible, some patients even opt to forego care entirely rather than settle for care to which, for whichever reason, they are opposed. More perniciously, negative experiences of accessing care in the official health system often drive residents to Johannesburg's underworld, where a large range of (often dangerous) "alternative" treatments or "alternative" ways of accessing mainstream treatments, abound.<sup>49</sup>

A significant factor impacting on the acceptability of health care (and thus on patients' choices of whether and where to access health services), is the manner in which patients are treated by both administrative and medical personnel at health care facilities. This is particularly an issue for marginalised residents, who sometimes face hostile or abusive treatment when presenting for care. Foreign migrants, for instance, regularly complain of xenophobic hostility and abuse at Johannesburg's public hospitals and clinics. Examples of this include migrants being refused care when they are not able to produce identity documentation or being made to wait for treatment until all South Africans at the facility have been helped, as well as staff being verbally abusive or refusing to speak English to foreign patients. These incidents are so widespread that many foreign migrants, especially those who are in the country illegally, tend either to avoid seeking health care altogether, or access care only from the private sector (when they can afford to do so) or from service providers in the non-profit sector.<sup>50</sup>

Similarly, people who seek sexual or reproductive health care often complain of stigmatisation, humiliation and hostility from health care workers, in both the public and private sectors, to the point where this leads them to forego access to care. This is especially the case where their sexual or health seeking behaviour departs, in one way or another, from hegemonic societal morals. Women who attempt to access termination of pregnancy services, for instance, are often treated with contempt by nursing staff or administrative personnel, especially in townships. Although tales of women being turned away from hospitals or clinics when attempting to access termination services because of health workers' conscientious objections more often emanate from rural areas than from cities,<sup>51</sup> the high number of backstreet abortions that continue to occur in Johannesburg annually, notwithstanding a statutory entitlement to free termination services at public health institutions,<sup>52</sup> illustrates that such barriers to access are equally real in the city.<sup>53</sup>

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<sup>48</sup> Le Marcis (2008) at 177.

<sup>49</sup> See Le Marcis (2008) at 180-87.

<sup>50</sup> See Landau (2006) at 320; Veary (2010) at 40; Veary (2008) at 267-69; Veary (2013) at 130; Zihindula G, Meyer-Weitz A & Akintola O "Access to health care services by refugees in Southern Africa: a review of literature" (2015) 16(1) *Southern African Journal of Demography* 7 at 27-8.

<sup>51</sup> See Ngwena (2000) at 33-39; Ngwena C "Conscientious objection and legal abortion in South Africa: delineating the parameters" (2003) 28 *Journal for Juridical Science* 1 at 13; SAHRC (2007) at 48.

<sup>52</sup> Women are entitled to access free termination services on demand in the first trimester of pregnancy, in terms of s 2(1)(a) of the Choice on Termination of Pregnancy Act 92 of 1996 read with s 4(3)(c) of the National Health Act 61 of 2003. After the first trimester, terminations are only allowed in limited circumstances, delineated in ss 2(1)(b)-(c) of the Choice on Termination of Pregnancy Act. On the implementation of all of these provisions, see Pieterse (2014) at 40-41.

<sup>53</sup> See Pickles C "Lived experiences of the Choice on Termination of Pregnancy Act 92 of 1996: bridging

Similarly, sex workers complain of hostility and humiliation when attempting to access services, such as, post-exposure prophylaxis ('PEP')<sup>54</sup> and testing and treatment for HIV and other sexually transmitted diseases, to such an extent that it often leads them to give up on seeking treatment.<sup>55</sup> The same goes for LGBT persons and men who have sex with men, especially (though by no means exclusively) in township spaces which remain particularly hostile to homosexuality.<sup>56</sup> As with women seeing termination of pregnancy and people seeking treatment for HIV/AIDS, community stigma and associated internalised shame further often mean that such residents do not want to be observed by those who might know them when they access sexual health services. The result is that they tend not to access such treatment at their local health care facilities, but rather travel much further to access it, more anonymously, elsewhere.<sup>57</sup> When far-off facilities then refer them back to their local clinics or hospitals in an attempt to drive home administrative health district sensibilities, this often constitutes a de facto denial of access to care.

Overall, it is clear that physical journeys of accessing health care in Johannesburg are not simply determined by the location and physical availability of health care services in the city. As Frederic Le Marcis observed (in relation to Johannesburg specifically):

The quest of the sick does not acknowledge the administrative health divisions of the city but follows the principles of a search for optimum care. This quest transcends the suburbs of the rich or poor, black or white, just as it transgresses the rules of a medical system that sends patients from one health center to another higher up the chain. It involves journeys that are as much a function of an individual's state of health ... as his or her financial resources. In this context, mobility is not a temporary state but – for the poor population living on its periphery – the very condition of survival in the city.<sup>58</sup>

Physically locating health care facilities within people's geographical reach is clearly only the first step to ensure that they are enabled to meaningfully access such services.

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the gap for women in need" (2013) 29 *SAJHR* 515 at 516-17, 519-21 and 527; SAHRC (2007) at 45-6.

<sup>54</sup> On the barrier posed by stigma in relation to access to PEP, which is only effective if physically accessed within a 72-hour time period, see Pieterse M "Impeding access? stigma, individual responsibility and access to post-HIV-exposure-prophylaxis (PEP) in South Africa" (2011) 30 *Medicine & Law* 279.

<sup>55</sup> See Richter M "Sex work, reform initiatives and HIV/AIDS in inner-city Johannesburg" (2008) 7(3) *African Journal of Aids Research* 323 at 328; Scorgie F, Nakato D, Harper E, Richter M, Maseko S, Nare P, Smit J & Chersich M "We are despised in the hospitals': sex workers' experiences of accessing health care in four African countries" (2013) 15 *Culture, Health & Sexuality* 450 at 454-56; Scheibe A, Richter M & Veary, J "Sex work and South Africa's health system: addressing the needs of the underserved" (2016) *South African Health Review* 165 at 170; Stadler J & Delaney S "The 'healthy brothel': the context of clinical services for sex workers in Hillbrow, South Africa" (2006) 8 *Culture, Health & Sexuality* 451 at 452-53.

<sup>56</sup> See Rebe KB & McIntyre JA "Towards 'men who have sex with men-appropriate' health services in South Africa" (2013) 14 *Southern African Journal of HIV Medicine* 52 at 52-3; Lane T, Mogale T, Struthers H, McIntyre J & Kegeles SM "They see you as a different thing': the experiences of men who have sex with men with healthcare workers in South African township communities" (2008) 84(6) *Sexually Transmitted Infections* 430; SAHRC (2007) at 45-6 and 52. On hostility towards and danger for LGBT persons in Johannesburg's townships and elsewhere, see Pieterse M "Perverts, outlaws and dissidents: (Homo)sexual citizenship and urban space in Johannesburg" (2015) 26 *Urban Forum* 97 at 105-07.

<sup>57</sup> Le Marcis (2008) at 179.

<sup>58</sup> Le Marcis (2008) at 192.

When geographical access to care is understood as being intertwined with acceptability and quality of care and as being impacted also by surrounding features of particular places, addressing these factors and enhancing people's mobility are revealed as being equally compelling.<sup>59</sup>

## 4 ENHANCING ACCESS

### 4.1 Increasing Availability and Enhancing Mobility

Both the National Department of Health and the City of Johannesburg Metropolitan Council have, through a range of policy and physical interventions, displayed commendable awareness of the geographic dimensions of the right to have access to health care services, and of the interdependence of these geographical dimensions with those of other socio-economic rights.

As part of the national health system's general emphasis on primary care and in readying the system for the introduction of national health insurance, the physical availability and accessibility of health services has long been a priority for the Department of Health. As far back as 2000, the Department's primary health care norms and standards expressed a commitment to increase the proportion of persons living within a five kilometer radius of primary health care clinics.<sup>60</sup> Its recently issued national health insurance White Paper envisages that "people will be able to access health care services closest to where they live",<sup>61</sup> and reiterates prior commitments to improving geographical distribution of primary health clinics and hospitals, as well as to improving inter-facility transport and ambulance services.<sup>62</sup> The White Paper further contains commitments to the extension of two major geographical interventions in terms of which primary health services will be brought to people *where they are*: municipal ward-based "primary health care outreach teams" led by nurses that perform health assessments in households and "provide health promotion education, identify those in need of preventative, curative or rehabilitative services, and refer those in need of services to the relevant primary health care facility",<sup>63</sup> and an intensified integrated school health programme providing mobile immunisation services and health assessments to children at their schools.<sup>64</sup> Both of these initiatives have been piloted at various sites across the country, including sites across Johannesburg, with early performance indicators in Johannesburg being positive for both.<sup>65</sup>

Unfortunately, there are some indications in the White Paper that its vision for

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<sup>59</sup> See Coggin & Pieterse (2015) at 304; SAHRC (2007) at 42.

<sup>60</sup> Department of Health *The primary health care package for South Africa – a set of norms and standards* (2000) at 12.

<sup>61</sup> Department of Health *National health insurance for South Africa: towards universal health coverage* (2015) at 1 and 25.

<sup>62</sup> Department of Health (2015) at 28-9 and 44.

<sup>63</sup> Department of Health (2015) at 32.

<sup>64</sup> Department of Health (2015) at 33.

<sup>65</sup> See City of Johannesburg *State of the city address 2016 delivered by the Executive Mayor, Cllr Mpho Parks Tau* (4 May 2016) at 18.

health care service delivery in terms of a national health insurance scheme will not always respond optimally to the geographical realities of access to care discussed above. For instance, the White Paper envisions that people will not be able to go directly to hospitals or medical specialists without having been referred from a primary health care facility, and also appears to restrict people to accessing primary care only at those clinic sites located closest to where they reside.<sup>66</sup> While these restrictions are understandable, the above discussion on the interlinkages between geographical availability and other determinants of access to health care services shows that they may have the effect of restricting meaningful access to care, especially for marginalised groups. In this respect, a further worrying feature of the White Paper is its seeming restriction of non-emergency free health services under the national health insurance scheme to South African citizens and refugees,<sup>67</sup> meaning that undocumented migrants' physical struggles to access health care, as detailed above, are likely to persist.<sup>68</sup>

For the most part, the City of Johannesburg's commitment to achieve the Department of Health's vision of enhancing access to primary health care has generally been impressive, and much resources and effort have been expended on increasing both the number of primary health care clinics across the city as well as the services that they offer. In this respect, it is particularly encouraging that the city's spatial planning policies explicitly include initiatives aimed at enhancing physical access to health care services and at improving residents' mobility across the city. The *Corridors of freedom* policy,<sup>69</sup> which aims to enhance spatial justice across the city by directly addressing the city's spatial fragmentation, envisages housing and public service development along public transport "corridors", which link outlying townships and other marginalised areas to both the inner city and business nodes in the northern suburbs. A central feature of *Corridors of freedom* is the introduction of an extensive bus rapid transit (BRT) system along the corridors. The roll-out of the first phases of the BRT system has showed particular awareness of the performative dimensions of access to health care and other socio-economic rights, with routes that have been operationalised thus far including specific designated stops in front of or near major public hospitals (such as Helen Joseph Hospital and Charlotte Maxeke academic hospital), while four new clinics are being built, and existing clinics are receiving major upgrades, along the corridors.<sup>70</sup>

## 4.2 Combining Accessibility with Appropriateness and Acceptability

Improving the geographic distribution and facilitating the physical reach of health care facilities in ways such as those discussed above go a long way towards enhancing access to health care services for those who live in underserved parts of the city. But the discussion in part 3 above also draws attention to factors peculiar to the experience of

<sup>66</sup> Department of Health (2015) at 25.

<sup>67</sup> Department of Health (2015) at 25.

<sup>68</sup> See Scheibe et al (2016) at 170.

<sup>69</sup> City of Johannesburg *Corridors of freedom: restitching our city to create a new future* (2013) available at <[http://www.joburg.org.za/images/pdfs/corridors%20of%20freedom\\_s.pdf](http://www.joburg.org.za/images/pdfs/corridors%20of%20freedom_s.pdf)> (accessed 24 June 2016).

<sup>70</sup> See City of Johannesburg (2016) at 6 and 18; South African Cities Network (2016) at 346-48. For a rights-based evaluation of *Corridors of freedom* and BRT, see Coggin & Pieterse (2015) at 308-11.

accessing care at particular institutions, and to interactions between different determinants of health care services, which impact negatively on people's willingness or ability to make use of available health services. In the parts that follow, I discuss two interventions which illustrate the potential of target group appropriate geographical interventions aimed at overcoming these hurdles, particularly in relation to marginalised residents. While these interventions are not the only initiatives aimed at enhancing access to health services by vulnerable and marginalised groups,<sup>71</sup> they have been selected for their particular responsiveness to the interactions between people's geographical practices and the other determinants of access to health care services, and for their location in central Johannesburg.

#### 4.2.1 *The Hillbrow mobile clinic*

The dilapidated, high rise apartment dominated inner city suburb of Hillbrow is synonymous with Johannesburg's sex and drug trade, and is also well known for its large population of (often undocumented) foreign migrants. Indeed, its residential hotels are the base for a large number of sex workers, many of whom are of foreign origin.<sup>72</sup> Apart from generally being poor, Hillbrow's sex workers are also legally vulnerable, due to the criminal status of sex work in South Africa, which is often compounded by their "illegal" migrant status.<sup>73</sup>

Sex work is heavily stigmatised and, as elsewhere in the city, Hillbrow's sex workers regularly complain of hostility from and humiliation by health care workers when they attempt to access treatment at nearby public hospitals or clinics. Together with the facts that foreign sex workers fear being reported to immigration authorities by health care staff, and that the opening hours of clinics and hospitals tend to be inconvenient for sex workers, these act as a definite disincentive to access care, especially in relation to sexual and reproductive health.<sup>74</sup>

Noting this, the University of the Witwatersrand's Reproductive Health and HIV Research Unit (RHRU) partnered with the Department of Health in 1996 to launch a weekly reproductive and sexual health clinic, targeted specifically at sex workers, in Hillbrow's Esselen Street. The clinic provided gynaecological services, STD testing and treatment, support for sexual assault, as well as birth control and condoms, among other services. Sex workers who used the clinic generally reported positive

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<sup>71</sup> In relation to sex workers and migrants, see for instance the prospective measures discussed by Scheibe et al (2016) at 171.

<sup>72</sup> See Leggett T "A den of iniquity? Inside Hillbrow's residential hotels" (2002) (November) *SA Crime Quarterly* 19; Richter M "Johannesburg's 'vendors of vice' – from Frenchfontein to Hillbrow: female sex work, migration and infection control (1868-2012)" unpublished paper presented at ACMS Colloquium *Ill people or sick cities? Mobility and access to health in South African cities* (3 October 2012), at 11-12; Richter (2008) at 328; Stadler & Delaney (2006) at 451-455; South African Law Reform Commission (SALRC) Project 107 Discussion Paper 0001/2009 *Sexual offences: adult prostitution* (2009) at 49.

<sup>73</sup> On the daily experiences of these vulnerabilities, see Veary J, Oliveira E, Madzimure T & Ntini B "Working the city: experiences of migrant women in inner-city Johannesburg" (2011) 9 *Southern Africa Gender & Media Diversity Journal* 228.

<sup>74</sup> Scorgie et al (2013) at 454-56; Stadler & Delaney (2006) at 452-53.



experiences.<sup>75</sup> From 2002 onwards, a mobile branch of this clinic, which would physically go to and operate out of particular residential hotels on a once-a-month basis, was introduced.<sup>76</sup>

Sex workers' response to this mobile clinic (which was eventually also extended to provide services to male and transsexual sex workers) has been overwhelmingly positive and the take-up of its services has been high. Sex workers report that the clinic's advantages include its geographical convenience (in that services came to them rather than the other way around, at times which were convenient to them and at private locations which could be accessed even by those who were too sick to travel to other facilities or who feared detection by immigration authorities), its discretion and respect for privacy, the approachable and sympathetic staff, the profession appropriate counselling and services, and the broader destigmatising effect that its operation had on the residents of particular, "healthy" hotels.<sup>77</sup>

The clinic's effect on the health and health seeking behaviour of Hillbrow's sex workers has been apparent. Studies comparing the working and living conditions of sex workers in Hillbrow to those of sex workers operating from apartments in the decidedly more upmarket Sandton, as well as with sex workers in other South African cities, have found that the Hillbrow-based sex workers tend to have more regular and dependable access to condoms, are more likely to report regularly engaging in "safe" sex and have significantly more contact with health services than those working in other places.<sup>78</sup>

#### 4.2.1 "Health 4 Men" in Soweto and Yeoville

The particular sexual health needs of men who have sex with men are neglected in most societies, and South Africa is no different. The result is that such men tend not to receive appropriate and targeted sexual health services, even though they have been shown to be at high risk for the transmission of HIV and other STDs.<sup>79</sup> This is so especially in relation to those men who do not consider themselves to be, or would not like to be known as, homosexual or bisexual. For a variety of cultural and historic factors, many Black South African men living in Soweto and similar Johannesburg townships fall into this latter category.<sup>80</sup> These men, even more so than their homosexual and bisexual counterparts, are unlikely to openly seek sexual health care services in a setting where this can be observed, and stigmatising conclusions about their sexuality be drawn. This

<sup>75</sup> Richter (2012) at 14; Richter (2008) at 328; Scorgie et al (2013) at 458.

<sup>76</sup> On the particulars of this clinic, see Richter (2012) at 14; Richter (2008) at 328-29; Stadler & Delaney (2006) at 459-61.

<sup>77</sup> See Richter (2012) at 14; Richter (2008) at 329; Scheibe et al (2016) at 172; Stadler & Delaney (2006) at 459-61.

<sup>78</sup> See Richter M, Chersich M, Temmerman M & Luchters S "Characteristics, sexual behaviour and risk factors of female, male and transgender sex workers in South Africa" (2013) 103(4) *South African Medical Journal* 246; Richter M, Chersich MF, Veary J, Sartorius B, Temmerman M & Luchters S "Migration status, work conditions and health utilization of female sex workers in three South African cities" (2014) 16 *Journal of Immigrant & Minority Health* 7 at 12-13; Scorgie et al (2013) at 457.

<sup>79</sup> See Lane et al (2008) at 432-33; Rebe K & McIntyre J "Providing HIV care to men who have sex with men in South African State sector clinics" (2014) 15(1) *Southern African Journal of HIV Medicine* 10.

<sup>80</sup> See Lane et al (2008) at 430; Pieterse (2015) at 105-7; Rebe & McIntyre (2013) at 52.

compounds the general negative experiences of men who have sex with men seeking to access sexual health services in South Africa, as discussed above.

Following on the introduction of a similar programme in Cape Town,<sup>81</sup> the Anova Health Institute, backed by foreign donor funding, partnered with the Department of Health to launch a sexual health clinic targeted specifically at men in Soweto. The Health 4 Men clinic provides free HIV and STD testing and treatment, PEP treatment, as well as general sexual health counselling and medical advice. It serves all men regardless of sexual orientation, but its staff are trained to be particularly aware of, as well as sensitive and sympathetic to, the sexual health needs of men who have sex with men. Care was taken to dissociate the physical appearance of the clinic from any particular sexual orientation or from the (stigmatised) concept of STD infection. After initial reports showing that men welcomed the clinic and made use of its services, but that many Soweto men were still hesitant to use such services at a site where they were known to health workers and community members, a second Health 4 Men clinic was opened in the inner-city suburb of Yeoville, where it has been integrated into the general community clinic that operates there.<sup>82</sup> Health 4 Men advertises its services in the LGBT press as well as in all-male saunas and sex clubs (where, indeed, it has on occasion offered on-site HIV testing and counselling services), and also has a significant internet presence.<sup>83</sup>

Early indications are that the initiative is being well received and that the clinics are widely utilised by Johannesburg men who have sex with men, across differences in race, class, sexual orientation and (especially in the case of the Yeoville clinic) suburb or area of residence.<sup>84</sup>

## 5 ANALYSIS AND CONCLUSIONS

Access to the objects of socio-economic rights refers to more than the ability to seek satisfaction of socio-economic needs. By focusing on the agency and actions of those who attempt to exercise their socio-economic rights daily, a performative understanding of access to socio-economic rights draws attention to hurdles to the enjoyment of such rights that are constituted across determinants of availability, accessibility, acceptability and quality.

By taking a closer look at the manner in which health care services are accessed in Johannesburg, this article has pointed, first, to lack of mobility and, secondly, to the interaction between the availability of health care services and other determinants of access to care (notably, acceptability and accessibility) as constituting barriers to access to health care services in the city. While health services at all levels of care are generally available and equitably distributed across Johannesburg, the article showed that, due to this interaction, they are not always meaningfully accessible. This means that State

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<sup>81</sup> See Rebe & McIntyre (2013) at 54.

<sup>82</sup> Rebe & McIntyre (2013) at 54 and 57.

<sup>83</sup> <<http://www.h4m.mobi>> (last accessed 24 June 2016).

<sup>84</sup> Rebe & McIntyre (2014) at 10-11.

efforts to improve access should not only focus on the availability and distribution of health services, but also on whether they respond to residents' peculiar needs and geographical realities.

While the article has therefore welcomed policy and urban management initiatives aimed at increasing the availability of health services across Johannesburg and at making it easier for residents to reach them, it has also pointed to some fault lines in current policy thinking on access to health care. In particular, the discussion showed that it should not simply be accepted that people will be willing or able to access health care at specific facilities located closest to where they live.

The implementation of health policies (and, in particular, the national health insurance scheme) must therefore allow for some flexibility in relation to where people are allowed to access care. Ensuring that people are able to easily traverse the city in order to access care further away from home where this is necessary (as is commendably being achieved by the City of Johannesburg's *Corridors of freedom* initiative) is also essential.

Policy initiatives and health system reform should further aim to ensure that quality of care is consistent across the city, so as to minimise the need to travel in search of optimal care. Moreover, policy efforts should address other aspects of health service delivery (in particular, the way in which "sensitive" services, such as reproductive and sexual health services, are rendered, and the behaviour of health care professionals and administrative staff towards marginalised patients) which may discourage people from accessing care close to where they live.

Given that the working of the health system is but one feature of life in the city, it will sometimes be necessary to tailor services in ways that respond to the particular geographical and social realities of their targeted recipients. The ward based primary health care outreach teams and integrated school health programme championed by the national health insurance White Paper are therefore welcomed. However, the article has also shown that extra measures will be necessary to respond to the needs of particular marginalised groups. The examples of sexual health services aimed at marginalised groups discussed in part 4.2 illustrate that it is possible to structure health care service delivery in ways that make services geographically convenient for prospective patients while at the same time ensuring that conditions that would discourage them from making use of such services are minimised.

The characteristics of the sites at which rights are performed, as well as the ways in which access to those sites is gained, are clearly important. Policies and programmes aimed at progressively realising socio-economic rights should take the geography of the performance of rights into account. Solutions do not always lie in providing more services in more places, but rather in empowering people to reach those services that do exist, and in tailoring services in such a way that, once reached, they are truly accessible.