

CHAPTER 1: INTRODUCTION

1.1. Vision

Our vision is a caring and humane society in which all South Africans have equal access to affordable, good quality health care.

1.2. Mission

Our mission is to create an effective enabling framework to guide the process of developing, implementing and monitoring laws, policies, programmes, procedures and practices which will serve to mobilise for

- 1.2.1. Equitable attention to the health needs of women and men and girls and boys and equal access to quality of care at all levels of the health system; and
- 1.2.2. Equal rights and opportunities for both women and men within the Department of Health and the Public Health Institutions.

1.3. Policy guidelines

The Gender Policy Guidelines have been developed in order to systematise the process of gender mainstreaming. The guidelines will support the Department of Health and Public Health Institutions in ensuring that gender-related issues are identified and addressed across all directorates and institutions. They will support this process at national, provincial and local levels, both within the Department and in its programming.

The policy guidelines are as follows:

- 1.3.1. Creating an enabling policy environment for translating the commitments of the Department of Health in rendering gender equality a reality;
- 1.3.2. Establishing an institutional framework within the Department of Health and the Public Health sector for the advancement of the status of women as well as the achievement of equality between women and men;
- 1.3.3. Integrating the empowerment of women and transformation of gender relations into policies and programmes at all levels of the health system; and
- 1.3.4. Promoting new attitudes, values and behaviour, and a culture of respect and gender equality throughout the health system

1.4. Principles

Government has committed itself to promoting gender equality. It has established machinery, in the form of the Office on the Status of Women (OSW) and Gender Focal Points (GFPs) in most departments. These have been established to support and monitor government's efforts to promote gender equality. However, responsibility for implementation lies not with these units, but with senior management of government. This is in accordance with the principle of 'mainstreaming' gender.

As gender inequities have an impact on the quality and efficiency of the mainstream of internal and programming activities of the Department of Health, gender relations must not be addressed as a separate stream of activities. Gender inequities are best addressed within the mainstream of daily management processes of the department and public health institutions. For this reason implementation of these guidelines is primarily the responsibility of senior management within the Department of Health and the Public Health Institutions. The following principles establish this approach:

- 1.4.1. Gender inequities impact on the ability of the Department of Health to achieve its mission of promoting and monitoring the health of all people in South Africa and to provide caring and effective services through a primary health care approach. For this reason, they will be addressed in all areas of the Public Health Sector as an integral part and not as a separate or parallel gender programme.
- 1.4.2. Management of national, provincial, district and local directorates and institutions in the health system are responsible for implementation of these guidelines.
- 1.4.3. Management will build implementation of this policy into its own performance agreements as well as into those of staff under its management.

Identifying and addressing barriers to gender equality is difficult, given the pervasive culture of devaluation of women in our society. There are, however, non-governmental organisations that are giving priority to this challenge and have the expertise to identify and suggest ways of addressing diverse dimensions of gender inequality. There are community-based organisations which are able to represent the experience and concerns of women as the group which suffers most from current gender norms and inequalities. In order to enable them to support the department in its endeavour to mainstream gender and in order to support the department in communicating and implementing its objectives, these guidelines are also based on the principle that:

- 1.4.4. During the process of implementation of these policy guidelines, managers will create opportunities for collaboration with civil society stakeholders in the health sector.

1.5 Rationale: “gender” as a health issue

1.5.1. Women and men have different health needs.

Given that there are some biological differences between women and men, disease may follow different patterns in women and men’s bodies, and may thus require different prevention and treatment approaches.

However, most differences are not the result of biology. Women and men’s health status reflects differences in gender norms – that is in the different expectations, value and treatment that society accords men and women. The nature of the interaction between discrimination and health status is the same as in the case of race discrimination. Historically, race classification determined health status in South Africa. The lesser access of black people to economic resources, information, education, and quality health services, and the overall impact of both poverty and disempowerment, is reflected in their poorer performance on health indicators such as infant mortality, vulnerability to disease, communicable diseases and so forth. Understanding the impact of gender norms on health status requires a similar analysis as of the impact of racial discrimination in allocation of resources. Only by understanding, this that health needs in terms of gender could be addressed systematically.

1.5.2. Social determinants of vulnerability

Women and men’s exposure to health problems often differs because of the division of labour – for example, they may face different hazards in the workplace. While men have exposure to silicosis in mining, women have exposure to brown lung disease from cotton dust in the textile industry. This is one way in which the gendering of roles makes women and men subject to illnesses in different ways. The double shift – housework and waged labour in the case of women – is another example of gender inequality with health consequences for women.

The double shift is only one dimension of gender inequality that influences health. The pervasive devaluation of women also has a direct impact. For example, the high levels of violence against women in South Africa suggest that our society considers violence against women acceptable. This reflects lack of recognition of women as equals, with an equal right to dignity and respect as that of men. Violence against women in turn manifests not only in physical trauma but also in mental health problems. It also links directly to the HIV/AIDS pandemic, with recent studies indicating that sexual coercion of young women is commonplace. This means that because of inequality in matters of decision-making pertaining to sex, women cannot protect themselves from HIV.

Likewise, men may be vulnerable to different health problems from women because of their social expectations such as how men should behave. In relation to HIV, the social expectation of young men to have sexual experience and prove prowess may push them into unsafe sexual practices. The social expectation of men to be tough, coupled with the increasing economic vulnerability of young men as they face a future without a job,

increases the acceptability of violence as a means of resolving conflict and insecurity. Thus addressing health requires understanding that gender differences and inequalities in themselves cause ill health.

1.5.3. Differential access and resources

Gender differences and inequalities also influence health-seeking behaviour. Women and men have differential access to resources. For example, being a member of a medical aid scheme, having an occupational nurse in the workplace, having access to transport or to money for transport to get to a clinic have impact on health seeking behaviour between the sexes. In addition, women need access to childcare in order to have the time to access health care, having information about service availability and the right to care – these are factors that have a bearing on whether or not women and men seek health care.

1.5.4. Institutional response

As institutions of society, both the Department of Health and the health system as a whole are influenced by institutionalised gender inequality. Gender inequality is embedded in most institutions in society. This is for two reasons. Firstly, most institutions are controlled by men, and usually by particular groups of men (the educated, labour ‘aristocrats’, wealthy, hereditary leaders, etc.). Over the course of time, institutional goals, management styles, inter-personal culture and the like become consolidated, so that whether women take up leadership posts or not, the ‘way of doing business’ is already established.

Secondly, institutions reflect the general social culture – the gender norms of society. If society does not value women’s input, social institutions are unlikely to do so. If society does not give women access to decision making, its institutions are unlikely to do so. If society does not give priority to women’s health, health institutions are unlikely to do so. It is likely that in an institution, which has inherited and perpetuates the devaluation of women, programming of activities will likewise reflect this bias. Thus in these health institutions, less attention may be given to women’s health needs than to men’s.

1.5.5. Impact of gender inequality on health workers

Health providers experience gender power relations from two sources. Firstly, most health workers are women. As women, they experience the same institutional and relationship inequalities as those facing all women – in the home and in society. The health service culture does not take account of women’s double load. Requirements such as varied shift hours of work place substantial stress on women who are mothers, in addition to the general stress of shift work that is experienced by all shift workers. Women health workers are frequently exposed to the same hazards as their clients, such as violence against women. The workplace exacerbates this. For example, nurses working alone at night in clinics face the risk of assault at the clinic or on their way to and from work in the dark.

Secondly, within the health system, nurses are at the bottom of a gendered institution, with rules, procedures and a culture established without women's input. In addition, the nursing profession has a structure regimented like an army, which is driven from above and does not promote collective decision-making or input from below. The doctor-nurse relationship reinforces this hierarchy, perceiving nurses as subordinate and putting them at the receiving end of instructions. Yet as front-line providers, frequently running rural services on their own, nurses' ability to innovate and make responsive decisions contributes to the effectiveness of the health system.

1.5.6. Failure to address gender issues in reproductive and sexual health

Frequently programmes concerned with gender and health focus on addressing women's reproductive health needs, at the expense of considering men and women's health across the board. Alternatively, they focus on women at the expense of men. Addressing gender means looking at how unequal power relations between men and women affect health, health-seeking behaviour, health outcomes and health services in general.

In a context where there are no reproductive health services, the reasons for their absence may be gender-related. Given the direct link between reproductive health services and maternal mortality and morbidity, failure to provide reproductive health services may indicate lack of value attached to women's lives and health.

However, provision of reproductive health services, even if these are to both women and men, does not necessarily mean addressing the gender dimensions of reproductive health. For example, programmes aiming to get women to deliver at health centres often fail to recognise that gender issues – such as men's control over access to transport or women's inability to leave children behind – may be hindering women's ability to access emergency obstetric care on time. Interventions to build men's support and understanding of the need for health centre deliveries may be a critical reproductive health intervention.

The same applies in the field of sexual health. Programmes for AIDS prevention frequently avoid dealing with gender-related issues such as promoting communication about sex, and equality and mutual respect in sexual decision-making between men and women, despite the fact that this is the central problem in vulnerability to HIV. People are called upon to use condoms or to be faithful without challenging women's lesser power to negotiate sexual behaviour, that is, without addressing the gender dimensions of vulnerability to HIV.

For all of these reasons, the Public Health Sector needs to understand how gender roles, norms and values impact on women's and men's health and health-seeking behaviour, as well as on the operation of the health system itself and its priorities. This understanding will allow all units within the Department of Health to frame both their internal practices and their policies and programmes in such a way as to further social justice and improve both the efficiency and quality of health care.

1.6 Background and achievements

1.6.1. International commitments

1.6.1.1. Convention on the Elimination of All Forms of Discrimination Against Women

In December 1995, the South African government ratified the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW). This step legally bound Parliament and the executive to work actively towards abolition of gender discrimination in the governance of the country.

CEDAW includes an article on eliminating discrimination against women in the field of employment. In addition, of particular pertinence to health, it requires 'state parties' to:

- ❑ Eliminate discrimination against women in the field of health care in order to provide, on a basis of equality of men and women, access to health care services; and
- ❑ Provide the right of rural women to have access to adequate health care facilities.

Subsequent to the development of CEDAW, two United Nations conferences have produced consensus documents, which elaborate state parties' responsibilities in relation to gender and health. These documents were utilised by the Committee on the Elimination of All Forms of Discrimination against Women in their interpretation of CEDAW. South Africa contributed to the development of consensus at both of these conferences. They are the Programme of Action of the International Conference on Population and Development held in Cairo in 1994 and the Fourth World Conference on Women held in Beijing in 1995. Both conferences committed state parties to extensive actions in order to promote gender equality in health and health services.

1.6.1.2. Convention on the Rights of the Child

While the Convention on the Rights of the Child is a gender-neutral agreement, it does carry some provisions related to gender and health. It requires state parties to provide

- ❑ Access for both girls and boys to health care and health information;
- ❑ Appropriate services for disabled boys and girls so that they suffer no discrimination;
- ❑ Effective and appropriate measures to abolish traditional practices prejudicial to the health of children. These could include gendered practices such as male circumcision or female genital mutilation;

- ❑ Protection of children from all forms of sexual exploitation and abuse;
- ❑ All appropriate steps to promote physical and psychological recovery and social integration of child victims of any form of neglect, exploitation, abuse, or armed conflict.

The recommendations of both the above conventions are directly relevant to the South African context, given the specific and different experiences of female and male adolescents during the period of political struggle and in the current HIV/AIDS crisis.

1.6.1.3. Gender Policy for World Health Organization

The World Health Organization (WHO) has recently developed its own gender policy. The policy provides a benchmark for member states.

The goal of the Gender Policy for WHO is to provide better health for both women and men, through health research, policies and programmes which promote equity and equality between women and men of all ages. The policy notes that equality between women and men has both a quantitative and a qualitative dimension. A quantitative one in that women and men are represented in equal numbers in all sectors. And a qualitative one in that the knowledge, experience and values of women are taken seriously and given equal weight to those of men and are used to direct and enrich health research, policies and programmes.

The specific objective of the policy is to include an analysis of gender issues in the activities, policies, programmes and projects of the World Health Organisation in order to:

- ❑ Increase coverage, effectiveness and efficiency of WHO's programmes and projects;
- ❑ Promote gender roles and relations that protect health, promote equality between women and men and contribute to the attainment of social justice; and
- ❑ Provide information and policy advice to member states on the influence of gender on health and health care, based on both quantitative and qualitative data.

The strategy to achieve the above objectives is to incorporate a gender analysis in all the work of WHO's programmes.

The approach to mainstreaming gender in health presented in the Gender Policy for WHO is the same as that used in the Gender Policy Guidelines for the Department of

Health. This indicates that the Gender Policy Guidelines are consistent with international experience and current trends.

1.6.2 Regional commitments

1.6.2.1. Policy and Institutional Framework for Gender Mainstreaming in SADC

In February 1997, the SADC Council of Ministers passed a Declaration on Gender and Development that established a policy framework for mainstreaming gender in all SADC activities and strengthening the efforts of member countries to achieve gender equality. On 14 September 1997, the SADC adopted an addendum to this declaration entitled *The Prevention and Eradication of Violence Against Women and Children*, which commits member states to the eradication of norms, religious beliefs, practices and stereotypes which legitimise and exacerbate the persistence and tolerance of violence against women. These provide the framework within which the SADC commits member states to promote gender equality in relation to health and health care. Of particular relevance in the context of the HIV/AIDS pandemic, the Declaration on Gender and Development commits member states to recognising, protecting and promoting the reproductive and sexual rights of women and girls.

1.6.2.2. Health Sector Framework Policy Document for SADC

The SADC Health Sector Policy Framework Document of 1998 is a gender-neutral document in that its analysis, objectives and indicators do not assess whether health or health service problems have any gender specificity, even in areas such as mental health, nutrition, disability and child sexual abuse. However, it does recognise a range of health problems that are particular to women because of their reproductive role. In relation to these, it commits member states to review, reform and formulate laws to promote the human and reproductive rights of women, and to promote community mobilisation and advocacy for women's rights and maternal health issues. It also commits each member state to undertake culturally sensitive research to determine the prevalence of genital mutilation. In addition, it addresses gender discrimination in relation to teenage pregnancy.

1.6.3. The national legal commitment to gender equity and equality

The Gender Policy Guidelines for the Department of Health establish mechanisms for the Public Health Sector to progressively move towards implementation of South Africa's constitutional commitments, as well as the international treaties cited above. They are in keeping with the national gender machinery laid out in the National Policy Framework for Women's Empowerment and Gender Equality.

1.6.3.1. Constitutional commitment to gender equality

These policy guidelines are a contribution towards consolidation of South Africa's constitutional commitment to gender equality. The Constitution holds that the state may not unfairly discriminate directly or indirectly against anyone, including on grounds of sex or gender. It also carries a number of other provisions which are relevant to gender equality in the health field. These include:

- ❑ Right to freedom and security of the person, including the right to be free from all forms of violence either public or private sources; bodily and psychological integrity which includes the right to make decisions concerning reproduction; the right to security in and control over their body; and not to be subjected to medical or scientific experiments without their informed consent;
- ❑ Right to privacy;
- ❑ Right to an environment that is not harmful to health or well-being;
- ❑ Right to have access to health care services, including reproductive health care; sufficient food and water; and social security; no one may be refused emergency medical treatment;
- ❑ Right of every child to family care or parental care; basic nutrition, shelter, basic health care services and social services; and to be protected from maltreatment, neglect, abuse or degradation.

In addition, provisions such as education, housing and labour relations are pertinent to gender-related causes of ill-health, since currently women have more limited access to these resources, resulting in poorer health and less access to health care than men. The Gender Policy Guidelines for the Department of Health establish mechanisms for the Department of Health to progressively address its constitutional commitments.

1.6.3.2. National Policy Framework for Women's Empowerment and Gender Equality

The National Policy Framework for Women's Empowerment and Gender Equality aims to establish a clear vision and framework to guide the process of developing laws, policies, procedures and practices which provide equal rights and opportunities for women and men in all spheres and structures of government, as well as in the workplace, the community and the family. Within this it aims to:

- ❑ Create an enabling policy environment for translating government commitment to gender equality into reality;
- ❑ Facilitate effective integration of gender considerations into all aspects of government policies, activities and programmes;

- ❑ Establish an institutional framework for the advancement of the status of women, as well as the achievement of gender equality; and
- ❑ Advocate for the promotion of new attitudes, values and behaviours and a culture of respect for all human beings.

The policy framework's principles, proposals and provisions apply to all departments of government at all three levels of government, that is national, provincial and local. The Gender Policy Guidelines for the Department of Health is the first step in the Department of Health's implementation of the National Policy Framework for Women's Empowerment and Gender Equality.

1.6.3.3. Promotion of Equality and Prevention of Unfair Discrimination Act of 2000

The purpose of the Promotion of Equality and Prevention of Unfair Discrimination Act of 2000 is to facilitate the transition to a democratic society, united in its diversity, marked by human relations that are caring and compassionate, and guided by the principles of equality, fairness, equity, social progress, justice, human dignity and freedom.

The legislation gives effect to Section 9 read with item (23) 1 of Schedule 6 to the Constitution of the Republic of South Africa Act of 1996, to:

- ❑ Prevent and prohibit unfair discrimination and harassment;
- ❑ Promote equality and eliminate unfair discrimination; and
- ❑ Prevent and prohibit hate speech.

Amongst others, the prohibition of unfair discrimination on ground of gender is dealt with specifically under Chapter 2 of the Promotion of Equality and Prevention of Unfair Discrimination Act.

1.6.4 Achievements and challenges within the Department of Health

Gender issues appear to have been firmly established within the overall framework of the public health sector in South Africa.

1.6.4.1. Building gender equality within the health delivery system itself

The White Paper for the Transformation of the Health System in South Africa commits to developing a strategic change management programme to facilitate a process of institutional change at all levels. Within this, affirmative action policies will address imbalances of the past in the composition of the labour force with regard to race and gender. It argues that gender sensitivity should be applied in recruitment and promotion

practices, that conditions of service should include housing subsidies for married women and retirement practices should include equalising pension schemes and ages of retirement. Implementation of these policies has begun.

The department is taking steps to change both the gender and race balance in management appointments. At national level, a gender forum of managers has been established to identify obstacles to women's full participation and development within the Department of Health. Further steps are required, however, to create an enabling environment for women decision-makers, members of staff and health workers.

1.6.4.2 Gender-sensitive health policy and legislation

The White Paper for the Transformation of the Health System makes references to gender in relation to programming in a number of places. It makes a commitment to gender-sensitive support to communities in solving their nutrition problems. It says the National AIDS Control Programme will ensure that all its projects are gender-sensitive. It notes that common manifestations of mental health problems include gender and age-specific forms of violence and says that additional funds should be allocated for research on mental illness, substance abuse and violence with an emphasis on age and gender differentials. In relation to information, it says that communication will be participative, gender-sensitive, and that two-way, innovative and culturally acceptable methods of communication will be utilised.

It should be noted, though, that the white paper does not provide a systematic approach to identifying and addressing gender inequalities in the health system or in health programming. It is this gap that the Gender Policy Guidelines for the Public Health Sector aim to fill.

The Health Sector Strategic Framework 1999–2004 provides the overall strategies for building a functioning health system. Gender-specific interventions would fall within these. For example, it sets out objectives for strengthening the health information system within which the need for sex disaggregated data would be located. It provides for the establishment of community committees for all facilities to enable users' voices to be heard. Within these committees, goals to provide for women's equal representation need to be established. It aims to increase the use of community and home-based care and strengthen the support and referral mechanisms for patients and their caregivers. Within these facilities, strategies to build a culture of men's responsibility for care giving will have to be developed.

Since 1994, a number of government policy and legislative decisions have contributed towards gender equity. In health policy, decisions have been taken to provide free primary health care to all and free health care to pregnant women and children under five. This is a gender issue in that women's poorer economic position and greater use of public health services means that they suffer most if health services are not offered free of charge. Likewise, the clinic-building programme aims to increase access.

In addition, a range of laws and programmes has been enacted to improve health and quality of care. The Tobacco Products Control Amendments Act (1999), while appearing to be gender blind and not addressing snuff use despite its widespread use by black women, will help to limit the ability of the tobacco industry to increase smoking levels amongst black women – a primary target. The Choice on Termination of Pregnancy Act enables women, including young women, to obtain termination of pregnancy services at public health facilities. While this is a reproductive health concern, it is also a gender issue because, besides contraceptive failure, women are frequently not in a position to prevent unwanted pregnancy, because of inequality in sexual and reproductive relationships. The national cancer control programme is introducing cervical screening, a gender issue because failure to address this preventable but predominant cancer killer reflects the lesser value put on women's health and lives by the previous government.

However, besides the considerable strides made since 1994 in attending to health problems within reproductive health, little attention has been given to identifying and addressing gender-based causes and their consequences on ill-health.

1.6.4.3. Improving responsiveness to client needs

The steps to implement *Batho Pele*, as well as efforts in many areas to promote patients' rights, are taking the Public Health Sector forward in addressing abuse of women clients and lack of adequate responsiveness to gender-specific problems such as violence against women. These are significant advances in a country that, until the dawn of democracy in 1994, paid scant attention to gender equality and gender equity in any area at all, let alone in the public health arena.

1.7. Assumptions

The ability of the Public Health Sector to deliver on these policy guidelines will depend on the support of staff at all levels of the department. A series of assumptions were made in developing these policy guidelines. These are that:

- 1.7.1. All management levels across all tiers of government will support the process of building an enabling environment for the promotion of gender equity and equality;
- 1.7.2. Directorates and institutions across all tiers will budget for and receive the necessary funds to undertake the activities required for the implementation of these guidelines;
- 1.7.3. The department will provide adequate funds for the Gender Focal Points (GFPs) to carry out the support and monitoring tasks assigned in these guidelines;
- 1.7.4. Management and health personnel will participate in training processes to enable them to conduct their work in a way that promotes equality and equity between women and men, girls and boys;

- 1.7.5. Senior management at all levels will co-operate with the GFP in order to implement the guidelines; and
- 1.7.6. The GFPs at national and provincial levels will co-operate in order to implement the policy guidelines.

The policy guidelines cannot be implemented if these assumptions are not taken seriously. For this reason, a first step in implementation is for the department as a whole to consider these assumptions and to be committed to their implementation.

Implementation of the Gender Policy Guidelines is the responsibility of management at all levels of the public health sector. In order to support management in meeting this responsibility, the GFPs at national, provincial and local levels will offer training, access to technical expertise and information they may need. The GFPs also have responsibility to monitor implementation.

