National Women's Health Status Report 1994 -2004
Ingxoxo Zamakhozikazi
National Department of Health
Pretoria

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1 INTRODUCTION

> *"Women are drawers of water, hewers of wood, labourers, preparers of food, bearers of children, educators, health care providers, producers and decision-makers. Although they are central to caring for families and communities, to production and reproduction, they are accorded an unequal status. Throughout the world, they are overworked and undervalued."*
>
> *Director, Division of Family Health*
> *World Health Organization*
> *Geneva, 1993*

The struggle for women's emancipation in South Africa is as old as the struggle itself. In the first instance, it is worth noting that women played a central role in production (and reproduction) during the pre-colonial era. While their societal roles remained different and separate from those of men, their central role as producers in agricultural and household economy accorded them a degree of status and authourity. With the advent of apartheid, which restructured the economy to serve its infamous migrant labour system, women lost their central economic role and their social status. As rural production declined as a result of factors such as adverse effects of the 1913 Land Act, women trapped in rural reserves were forced to identify survivalist strategies aimed at increasing household income. For those who later moved to urban areas, most were employed as domestic workers. While domestic service was known to be exploitative and abusive, it offered women food and shelter in an environment characterized by legal restrictions of movement as an attempt to curb a large influx of African people into urban areas.

As a response to increased attempts of apartheid government to enforce a systematic control of movement through pass laws, women stood up against Prime Minister Strydom and organized a massive anti-pass march to the Union Buildings in Pretoria on August 9th 1956. Two years before the historic women's march, the first women's charter was adopted at the founding conference of the Federation of South African Women in the same year that Bantu education minister Hendrik Verwoerd enforced a separate and unequal education system for African children. Way before the advent of feminism in the West in the 60s and 70s, South African women started a movement that situated women's emancipation within the context of a broader liberation struggle. At its core, the Women's Charter denounced and challenged a struggle for liberation that benefits only one section of the society. While they acknowledged the impact of apartheid on men in the mines and farms, they challenged obstacles to women's full participation in the struggle against poverty, race and class discrimination. Of greatest importance was a demand for equality in law and practice for women and men. The clauses of the Women's Charter were later incorporated into the Freedom Charter which was adopted by the Congress of the People at Kliptown on June 25 and 26 1955.[1]

Throughout the 70s and 80s, women remained active within political and trade union activities. Running parallel to this process was the development of a strong women's movement organised along sectoral lines such as health, violence, rural women etc. It is these women who formed the backbone of women in civil society and later became part of the National Women's Coalition. The Women's National Coalition was launched in April 1992 aimed at building on efforts of women who drafted and adopted the first Women's Charter in 1954. At its most basic, the
Women's National Coalition concerned itself primarily with overseeing and ensuring that the entrenchment of women's rights in the Interim Constitution becomes a reality.[2]

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[1] Beijing Conference Report: 1994 Country Report on the Status of South African Women

Women's National Coalition (1994): The origins, History and Process of the Women's National Coalition, Summary Report.

In this way, the introduction of the Interim Constitution and Charter for Fundamental Human Rights opened up prospects for actions to liberate women. Because women have suffered a long history of racial, class and gender oppression, the transformation of South Africa towards a new dispensation would therefore not be complete if it did not emancipate women. This fact brought with it a need to set up National Gender Machinery tasked with a role of formulating and implementing policies for women's advancement. Instead of opting for women's ministry, women met in a variety of settings and later agreed on a process of establishing a set of co-ordinated structures in government, legislature, independent bodies and civil society.[3]

Upon taking office in 1994, Government of National Unity set up the Reconstruction and Development Programme (RDP) whose main function was to spearhead a broader empowerment programme. Given the recognition that women are often the poorest, most exploited and most marginalised group, it was decided to set up an office for the co-ordination of the Gender machinery within the RDP office. Part of the RDP's gender office was to formulate a national women's empowerment policy[4] which ultimately culminated in what is now South Africa's National Policy Framework for Women's Empowerment and Gender Equality whose finalization was overseen by the Office on the Status of Women in the President's Office.

As a matter of policy, gender planning has been adopted in government programmes. One of the challenges remains mainstreaming gender-sensitive planning, implementation and evaluation within a public service which still lack gender analytical and planning skills among its policy makers and planners. Of the greatest of the challenges is streamlining government spending in ways that will enhance women's physical, mental, and spiritual well being. Women's health status therefore remains one of the most fundamental indicators for the state of any nation. It is indeed in the spirit of measuring how far have we come as a nation that this review report on women's health status is presented.

2 CONTEXT OF THE REVIEW

Important commitments to women have been a feature of most development and political processes at national, regional (SADC), Continental (African Union) and international levels. In many areas, the government can look with satisfaction at what has been achieved for women since 1994. The decade has seen substantial changes for women as a result of social, political and economic developments as well as changes in government

[3] Proposal for a National Women's Machinery in South Africa, Reconstruction and Development Programme: Office of the Minister Without Portfolio in the Office of the President, Pretoria, May 1995

[4] Imbhokodo, strike a woman strike a rock, 22 February 1996

policy and legislation. There has been an evolution of consultative mechanisms dealing with the needs and interests of women. The National Gender Machinery is well in place as well as National Policy on Women's empowerment.

While the decision to set up the National Machinery was to show a commitment to mainstreaming gender within government, a review in 1998 found that such structures neither have the capacity nor the resources necessary to carry out their function.[5] By virtue of their rank and power within government, many of the women occupying gender units do not have the authority or the skills necessary to make the necessary policy interventions. As of 1998, it was found that many of the government departments (except for health)[6] failed to report on the gender implications of their mainstream budgetary allocations. In the absence of a well- resourced and well co-ordinated strategy, gender remains at the danger of being ghettoized in spite of a commitment to mainstreaming. The lack of analytical training and of skills in impact of the budget on women's empowerment limit the National machinery's ability to translate women's needs into effective policies and programmes. Of equal importance is adequate staffing of gender units as well as mainstreaming of gender analysis in the public training courses carried out by the South African Management and Development Institute (SAMDI).

From the above, it is clear that ten years after setting out to implement an ambitious gender transformation programme means it is time to take stock. As we celebrate major achievements in government and civil society, it is also time to look critically at those areas where progress has been stunted or where there is still work to be done in developing clear implementation and/or evaluation measures. For South Africa, this comes at a time when the nation is preparing to celebrate its first decade of democratic governance.

It is in this light that activities and discussions/consultations were organized around the country, pre- and during the Women's Month (August), to afford women the opportunity to reflect on the government's achievements/challenges of ten years of democracy and vision and aspirations for the next ten years.

As one of those activities women from South Africa assembled at the University of Pretoria on 2 - 6 July 2003 under the theme South African Women in Dialogue.
The dialogue came at the invitation of Mrs. Zanele Mbeki and lists the following as some of its goals:[7]

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[5] Baden S, Hassim S and Meintjies S: Country Gender Profile: South Africa 1998. Report prepared for the Swedish International Development Co-operation Agency (Sida), Pretoria.

[6] Government of South Africa (1997a) Convention for the Elimination of All Forms of Discrimination Against Women: First South African Report Pretoria, Department of Welfare.

[7] South African Women in Dialogue (SAWID) Sowetan, Monday August 18th 2003

- reflect on our roles and experiences before the 1994 election
- acknowledge and celebrate our achievements since 1994
- identify and address ongoing challenges
- envision a plan towards our future
- draft a plan of action towards realization of our goals including participation in the New Partnership for Africa's Development (NEPAD) as well as the United Nations Millennium Development Goals towards the eradication of poverty
- assert Pan-African women's solidarity with the African Union's goals and programmes.

While the participants of the conference applauded the gains made by our democratic government in providing women with institutional, legal and political liberation, it was noted with great concern that South African women are still disadvantaged with the following identified as obstacles for women's full participation in development:

- food security - poor access to agricultural land and water
- poor access to clean water and sanitation
- poverty in rural areas and urban informal settlements
- inadequate facilities and poor management in hospitals, diseases including HIV/AIDS
- violence against women
- marginal participation of women in economic activities
- absence of a dedicated fund to promote women's empowerment
- absence of intergenerational dialogue and lack of programmes to integrate youth/young women in the socio-economic and political arenas.
- poor monitoring of implementation of government policies meant to empower women.

All participants committed themselves to strengthening and revitalizing the South African women's movement to levels, which would make realization of national, regional and continental development goals a reality.

The Office on the Status of Women, in the Presidency, spearheaded the build-up to the 26-27 August 2003 "Conversations Amongst Women" Conference. Different sectors (government, legislature, NGOs etc.) organized activities to facilitate a forum to enable women to assess the first ten years of freedom and to envision the next ten years. As part of the OSW-led process, the Gender Focal Point of the Department of Health set out to facilitate conduct mini dialogues in Gauteng, Mpumalanga and Limpopo. In addition to the outcome of these dialogue/meetings, the report draws from a range of policy and research reports compiled during the course of the decade. While we acknowledge the fact that health is closely related to sectors such as water and sanitation, economic empowerment, political participation and democratization, the report will limit itself to generic health. Where an interrelationship exists with other sectors, this will be duly noted. Furthermore, this report will focus on national status of women's health not in isolation but in line with various Continental and International mechanisms within which South Africa has taken part.

3 NATIONAL HEALTH STATUS: THE GENDER QUESTION

From the outset, integration of fragmented health facilities and administrations presented immense challenges.[8] With such integration came a need to improve accessibility of health services to the majority of people whose needs were not catered for during the apartheid era. Other challenges identified by the Department included ensuring that resources are allocated equitably to provinces. Included in that was a shift of resources to primary health care as well as the management of expenditure to ensure that the budget was efficiently utilized.[9] Beyond the obvious and immediate accessibility and affordability concerns was the greatest challenge of correcting past racial imbalance in respect of quality of care. Coupled with that was a dire need for training of health workers not only in skills but in inculcating a work ethic that encourages commitment and dedication to quality health for all South Africans.

In spite of all the immense challenges, policy and legislative reforms that benefit women were recorded early on. These include:

3.1 Universal access to Primary Health Care

In April 1996, the Minister of Health announced a policy on universal access to primary health care to increase basic health care for all South Africans. To achieve this goal, the Department embarked on a clinic upgrading and building programme. From the beginning of the programme (September 1995) till the end of 1998, a

[8] Department of Health Annual Report, 1996.
[9] Department of Health Annual Report, 1998.

total of 495 new clinics were built. In addition, a further 249 existing clinics were upgraded while some had maternity sections added to them.

As a result of the clinic building programme, about 7 200 permanent nursing posts were created with a further 3 850 jobs added for cleaning and security personnel. In addition, about 19 900 temporary jobs were created for construction workers for an average of six months with the total amount spent from April 1994 to December 1998 being R 730 896 772.[10] While this is applauded, it is not clear how many women, if any benefited economically from the Clinic building programme. It was only until later (2000) that the role of women in construction work was introduced as part of the Community Based Public Works programme.

Overall, universal access to Primary Health Care lends itself to benefiting women since the majority reside in outlying areas and are often in need of health care. In the case where their children or family members are the ones who need care, this still brings a sense of relief and frees their time because women are also burdened by the role of health care providers in their families.

3.1.1 Research Findings & Recommendations

It is clear that the strategy for primary health care improved access to health care for people who never had easy access before. However, there is still a lot more work that needs to be done. In the Women's conversations (Ingxoxo zamakhosikazi)[11] held with women in three districts in Limpopo and three areas within Ekangala district in Mpumalanga respectively, all the districts complained that the clinics are located far from residential areas[12]. Many still have to use transport to get to a local clinic. In some instances, the state of roads in some of the villages is so poor that community members have to walk long distances to access transport to reach health facilities. Such a situation further increases women's vulnerability to crime, which may even include rape. Women recommended that the community must be involved in identifying densely populated areas with easy access to public transport as the ones suitable for the location of the clinic.

In contrast to the above, women in Gauteng reported that the facilities are available and within reach. In addition, emergency services have improved with most reporting easy access to ambulance services although in some cases the latter

10 ibid.

11 For a list of questions used in women's focus group discussions see Appendix A

12 For a list of communities/districts visited see Appendix B

serve as a taxi, collecting and delivering people to and from different locations. This means, a pregnant woman or a critically ill person may suffer as a result.

It was further reported that most of the clinics operate only during the day on weekdays. This means, a woman who gets sick during the weekend or at night will have nowhere to go. It was further noted that lack of security for health workers discourages them to work at night.

Beyond location of the clinics, women in the rural areas complained of a shortage of medication. In most instances, after taking all the trouble to get to the clinic, they are often send home without appropriate medication. In other cases, some reported to have received diluted medication such as Panado syrup. While some women agreed that "half a loaf is better than no bread", others felt that diluted medication will not heal the illness. It was also noted with concern that some of the patients misuse the medication e.g. dumping the medication in the clinic's dustbin. This may be attributed to the fact that the communities are not fully aware of the cost implications of their actions. It may be free health care to them but there is a definitely huge cost implication to their government. It is clear that there is a dire need for education on these matters. There is a general perception in the public that anything that belongs to government is open to misuse. This can be attributed to the fact that most of us still view government in the same way that we viewed apartheid government. There is still a prevailing notion that resources belong to white people. Effecting a change in attitude insofar as ownership of resources and processes is concerned is one of the greatest challenges facing South Africa today.

Of greatest concern, is the report that health workers are failing in their role of treating people as human beings deserving of respect. Almost all the groups complained about poor time management on the part of staff with most going to lunch or tea break simultaneously while patients are waiting in long queues. While it is recognized that many health facilities are understaffed, this does not warrant poor interpersonal relations. It is worth noting that even though we have adopted the Transforming the Public Service Delivery White Paper that emphasizes the Batho Pele Principles that are essentially founded on Ubuntu/Botho philosophy, many of the health workers remain incapable of treating people with respect. Further, while the department has adopted the Patients Rights Charter, its successful implementation depends on educating both the staff and communities who come from a legacy of human rights violation.

Asked to identify some of the challenges facing their daily work, health workers came with the following list:

- Overwork
- Request forwarded to head office for clarification or support take long before being responded to.
- There is no time to give health talks to patients due to overcrowding at clinics.
- Health workers are reluctant to give education about termination of pregnancy because of traditional and cultural beliefs in the areas they operate in.
- It is difficult to apply skills acquired in training due to overwork and lack of time.
- Introducing Batho Pele Principles and Patient's Rights Charter without improving health services and working conditions has produced a nation of "complainers". Efforts made by health workers amidst serious constraints are not recognized.
- Patients forward "petty" complaints to provincial offices.
- Security guards working in local clinics are not sufficiently trained and armed to respond effectively to violence and crime.
- Generators are not readily available as a result delivery of health care is hampered by unexpected electricity cuts.
- There is a need for new equipment and facilities at local clinics such as bed linen, washing machines etc.
- Health workers affected emotionally by not only the case load but also by the stories and suffering that people have to go through. Lack of stress management for nurses is a serious concern. Stress accumulated in the workplace affect the health of their families.

A great amount of the transition needs to happen in people's psyche. While the government may find ways to address problems related to staffing, resources etc. it is essential that an atmosphere in which such a change in consciousness can be fostered should be created. In addition, a combination of Batho Pele principles with other international guidelines may be of use. To illustrate, UNFPA developed a Quality of Care Framework to be used in planning, implementation and assessment of reproductive health programmes. While such a framework has largely been used in countries such as India, it can be of relevance to South Africa.

Some of the elements of the framework include:

- **Access to services:** the location of services, availability of personnel, timing and cost are included in this component. The timing of health services is often

insensitive to women. For instance, health services are available in the morning when women are still occupied with fulfilling some of their household responsibilities. Improving quality would therefore include District Health Services (which the Department of Health has embarked on successfully), development and dissemination of professional standards, development of training protocols for communication, support for procurement and provision of essential supplies and equipment etc. All these and other related factors are contained in the Five-year objectives of the Department.

- **Service environment:** this includes organizing services to prevent long waiting periods, keeping premises clean and bright as well as ensuring privacy and confidentiality during consultations. Many of the women complained about the state of cleanliness at the clinics. A few volunteered to clean up the premises in line with Letsema campaign. Once again, community involvement remains at the centre of smooth running of services.
- **Client-provider interaction:** curbing the social distance between a health care provider and the community s/he serves is of critical importance. Attributes that include courtesy, empathy, active listening and respect for the client serve as the mirror of the public service. Support to health workers should go along with such training.
- Overall, the Department remains committed to delivering essential health services through District Health Services. A major reorganization during 2001/2 redefined health districts to coincide with the newly demarcated municipal areas.[13] This means, each health district can ultimately develop its own comprehensive plan and budget. This will therefore open up avenues for greater involvement with the community. The need to have more women involved at local government level cannot be overemphasized. Similarly, involvement of women in programmes such as Sustainable Rural Development Programme as well as Urban Renewal Programme means that they can influence health services to be "woman client-friendly". Because health cannot be separated from other issues such as access to water, sanitation, leadership development, employment and poverty alleviation, it is therefore essential that improvement of health conditions of affected communities should be included as part of the broader community development strategy.
- Ongoing consultation with communities is essential. In some of the districts, women expressed dissatisfaction with the manner in which policies are developed and finalized without their input. Some were concerned that most often consultations are rushed with workshops lasting for 1-2 hours convened hurriedly for local communities to comment on policies, which have already been agreed

[13] Department of Health Annual Report 2001/2

upon. There is no doubt that women's participation in public forums at local government level must be strengthened and encouraged.

3.2 Choice on Termination of Pregnancy Act (1996)

The Constitution makes provision for the right of access to reproductive health care. In response to this provision, government expanded reproductive health services to include adequate family planning counseling, free access to contraception, life skills for inclusion in school curricula as well as implementation of the Choice of Termination Act 1996 (Act No 92 of 1996). Regulations for the Act as gazetted in 31 January 1997 was followed by training for health workers on value clarification, use of manual vacuum aspiration and management of incomplete abortion. A total of 165 public hospitals were designated to perform termination of pregnancy. By the end of August 1997 which is essentially 6/7 months later, 15 545 terminations were done. Three months later (November), the number had increased to 24 387. [14] Up to the year 2001/2002, the total number of terminations was 216 718 while the incidence of severe morbidity associated with the procedure had decreased from 16.7% to 9.5%.[15]

When asked questions about the awareness of the Act and its implications for women's health, women in focus groups said that they had heard rumours about the Act but have not been educated formally about its implications on women's health. A few urban women who knew about the services were reluctant to talk about abortion in a group. Health workers and family often leave those who had to undergo termination of pregnancy to deal with the physical pain and guilt of "infant murder" without any counseling and support.

Overall, the term abortion is still equated with crime and is condemned for moral and religious reasons. In one of the discussions in Mammethlake area, women were totally opposed to the provisions of the Act. In their eyes, abortion is murder. They argued that even if a woman conceives as a result of rape, she should be supported to go through with the pregnancy and save the "innocent baby". They further argued that the Act contradicts the government's commitment to the moral regeneration in the society as well as promote the practice of unsafe sex. In KwaGuqa Extension 4, women felt that TOP services should be limited to exceptional cases, including rape and incest.

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[14] Department of Health Annual Report 1997

[15] Department of Health Annual Report 2001/2002

Coupled with a lack of information in a society characterized by a high rate of illiteracy, inability to discuss this matter openly does not help in addressing the fact that illegal abortions are still being performed. For teenagers, the situation is further compounded by reported negative and patronizing attitude of staff members.

3.4 **Contraceptive Methods**

The 1994 Cairo International Conference on Population and Development broadened the approach to family planning by emphasizing progress towards equality for women thus reducing maternal and child mortality as well as ensure access for girls to basic education and health services. With the expansion of Primary health care facilities, this translated to access to family planning for a majority of women.[16]

In the focus groups, women in rural and urban areas were satisfied with the education given by local health workers. However, their choice was, in some instances, compromised by a variety of factors such as the fact that their choice of contraceptives was not available at the clinic or health workers making choices on their behalf. In some cases, women reported lack of information with regard to side effects resulting in some (mostly teenagers) not using contraceptives at all. In other cases (Capricon & Waterberg Districts), women were prevented by their partners from using contraceptives with the latter complaining that contraceptives make them ill. In contrast, some of the women (Kwaguqa Extension 4) received encouragement and support from their partners.

The 1994 Cairo conference also broadened the concept of family planning to include changes in men's and women's knowledge, attitudes and behavior as a necessary condition for achieving a spirit of partnership between women and men. This came out of an acknowledgement that in most societies, men exercise sole power in every sphere of life. Further, contraceptives available to men such as condom and vasectomy was reported to be rarely used. An improvement of communication between women and men was therefore seen as a way of fostering joint responsibility so that women and men can become equal partners.

Seeing that young women in their first pregnancies are at greater risk of being affected by pregnancy related complications, it is essential that the efforts of the Department in improving health access to adolescents should be strengthened. The National Youth Development Policy Framework (2002 -2007) is an example

[16] ICPD 94, United Nations, 1995.

of a commitment of assisting young people in living their lives in preparation for the future. This policy is aimed at preventing conditions such as gender-based violence, unwanted pregnancies, sexually transmitted diseases, HIV, Tuberculosis as well as other forms of psychological trauma. In preventing teenage pregnancy, it is critical to work closely with young men. The tendency has always been to focus only on the teenage mother without empowering young fathers in making choices that enhances their future life prospects.

3.5 Mental Health Care

Five-year objectives of the Department aim to give attention to Mental Health in ways that include:

- a new Mental Health Care Act
- integrating mental health services into primary health care
- introducing preventative strategies that include reducing substance abuse
- implementing guidelines on treatment of rape survivors
- violence prevention mechanisms
- strengthen systems for community care and prevention.

In addition to the above, the Directorate of Mental Health and Substance Abuse has developed a number of programmes and policies "that include women's issues although not necessarily only focusing on women."[17] Included in the overall vision of improving the mental well being for all people in South Africa within the PHC approach are the following elements:

* A national project on Foetal Alcohol Syndrome launched by the Department in 1998. The main target group of the project is women of childbearing age. Epidemiological studies on this syndrome were conducted on three provinces namely Western Cape, Northern Cape and Gauteng. Primary Health care workers were trained on its prevention as well as how to assist pregnant women with a drinking problem. It is not clear from the report if the studies outlines causes of increasing levels of substance abuse amongst women. It is recommended that prevention mechanisms should take such factors into consideration. Further, addressing alcoholism amongst men and its impact on families is one of the most critical ways of reducing such a condition amongst women.
- The National Department of Health developed a project on mother to child bonding with pilots in Eastern Cape and Western Cape. The project's aim is to

[17] Directorate: Mental Health and Substance Report; Input for the Department of Health 10 years report on the Status of Women, August 2003.

encourage positive interaction between a mother and her child. This is shown to promote good mental health in the child and the mother and also reduces child abuse. It is not clear if the role of the father in child development forms part of the study. It is a well-known fact that the multiple roles that women play in the society without any visible support contribute to a breakdown in their mental health status.

- The Department, through the National Injury Mortality Surveillance System has found that in 2001, there were 18 876 non-natural deaths with young males outnumbering other groups. Firearms were identified as the cause of death in 28% of the cases with positive alcohol concentrations registered in 43% of firearm victims.[18]
- While prevention of violent deaths amongst young men may not be seen as a gender issue, research commissioned by Agisanang Domestic Abuse Prevention (ADAPT) on violent deaths of young men in Alexandra township in 1998 reveals the contrary. The study was guided by a belief that the plight of young black men cannot be ignored if society were to effectively address violence against women.[19] Violence against women could therefore not be simply understood as a sign of, or simply as men hating women but as a symptom of a deeper sense of alienation. This means, violence is a disease that destroys both the victim and perpetrator. It is in this light that ADAPT introduced a men's programme on violence prevention. The programme used theatre and seminars to assist men to talk about issues such as anger management, sexism, personal healing and development, role of a father in child development. Overall, the programme views the perpetrator of violence as someone who has potential to be part of the solution.[20]

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[18] Department of Health Annual Report 2001/2002

[19] Loate S: Research findings on violent deaths of young men in Alexandra Township ADAPT, 1998.

[20] Motsei M: Men about manhood. Forthcoming 2003.

There is no doubt that mental health care form one of the most critical areas of health. It is also very clear that mental health of women cannot be separated from their physical and psycho-spiritual health. Historically, the mental health needs of women were recognized largely to women's reproductive functioning. Lately, there is growing consensus of a need to address a lack of scientific knowledge that relates to gender differences in mental disorders. Such data would:

- Shed light on diagnosis and treatment of mental health conditions affecting women (including but not limited to their reproductive functioning). Included in the latter category would be stress associated to menarche and menopause in a society that views anything that is female negatively, post-partum depression, premenstrual syndrome and post-hysterectomy depression. Other conditions could include eating disorders and related self-harm disorders especially amongst young women. Research has shown that psychological problems in adulthood may be associated with problems in early childhood. For example, women's difficulties in their sexual relationships may be attributed to sexual abuse in their childhood, a condition that increases their vulnerability to mental disorders.
- Highlight socio-economic impact of factors such as poverty on women's mental health status. By virtue of being viewed as subordinate in a society, that in itself predisposes women to a variety of psychological conditions.
- Highlight the psychological impact of multiple roles on women. For instance, as more women desire and are encouraged to compete in the "men's " world in occupational terms and self-dependency, this needs to be accompanied by a significant change in the domestic division of labour. Failure to achieve such a balance would mean that more women would assume a larger burden of care, duty and responsibility in their public and private lives. This would in turn contribute to increased levels of stress resulting in a variety of psychosomatic conditions.

Beyond reproductive and active working lives, it is important to cater for health care needs of menopausal women. Often, a woman is viewed as a sex object or a breeder of children who is therefore valuable only when she is young. Such an attitude, fuelled by negative societal attitude towards the aged, reinforce societal myths that after menopause a woman is past what is called "sell-by date". Such an attitude has got serious implications on elder women's sense of worth and identity. Just like menarche and pregnancy, menopause is a natural phenomenon and women ought to be prepared for a healthy living. Acquiring information about how women's bodies change as well as forming support groups will go a long way in easing the discomforts associated with any phase in a woman's life.

Finally, it is important to also note that problems of old age largely affect women. In most countries, many women over 70 are widowed. This means, women account for a high percentage of the elderly. Similarly, those who car for the elderly are women. According to Census 2001, males aged 85+ are 45 907 as compared to 111 425 females. While we acknowledge the impact of HIV/AIDS on life expectancy, aging policies should cater for mental health care for elderly women. Included in such policies is a concerted effort in addressing elderly abuse. According to the Declaration of the Rights of the Elderly, older people should be able to live in dignity and security and be free of exploitation, physical and mental abuse.

3.8 Nutrition

Good health is a result of a balanced diet with adequate nutritional requirements. Women require greater amounts of nutritious food during their reproductive years particularly when pregnant and breastfeeding. Inadequate maternal diet and reduced nutritional reserves is known to impede foetal growth and infant development. It is in this light that the Department of Health has embarked on a comprehensive micronutrient control programme, which includes strengthening of food with vitamins and the broadening of the dietary intake. In addition, the Department has joined hands with the Department of Education in managing the Primary School Nutrition Program (PSNP) which is reported to have reached 5 million children in 14 000 primary schools throughout the country.[21] Community participation in the school-feeding project is encouraged with more than 53 000 community members involved in the preparation and distribution. A total of 30 924 community members received compensation.[22] Of these, it is not clear how many were women. A need for gender aggregated data in all aspects of health and development cannot be overemphasized.

3.9 Essential National Research (ENHR) Mechanisms

[21] Department of Health Annual Report 1998
[22] Department of Health Annual Report 1997

The Minister appointed an Essential Research Committee in January 2000.[23] The role of this committee is to look into issues related to health research nationally. Included in this function is ensuring that funding goes to priority research areas which address the needs of the country. Up to now, there has been very little research that painted a picture of differences between women and men. Consequently, until the major policy shift that distinguishes Maternal and Child Health from Gender Focal Points, [24] the tendency has been to focus on women's health only in their role as mothers. Firstly, such a focus tends to neglect other health needs of women that are not associated with their reproductive capacity. In some cases, misdiagnosis might occur causing serious consequences. To illustrate, some physicians might attribute what happens to a woman at midlife to menopause, sometimes overlooking what might be symptoms of some other serious disease. Secondly, focusing only on maternal health has resulted on very little knowledge about the health effects of specific diseases on women since the assumption may be the effects are the same on both women and men.

Closely related to the above is research on the role of race and ethnicity on health. Although there is growing literature highlighting this link, until recently the research on race and ethnicity excluded gender. Similarly, while feminist research has included the issue of race and ethnicity, white women researchers have often failed to address issues of black women being involved in defining relevant research questions. In order to determine the effects of race, ethnicity, geographical background and gender on health, large-scale quantitative and qualitative research is needed. As it is, we have very little information on the health of African women outside of specific diseases such as cancer of the cervix, STDs and HIV/AIDS. It is therefore critical that more African women researchers are trained in fields such as epidemiology, medical anthropology as well as other scientific and technical health fields.

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[23] Department of Health Annual Report 1999/2000

[24] Department of Health, Gender Policy Guidelines 2002

3.10 Tobacco control

Early in 1997, the Department convened a workshop that recommended that the Tobacco Products and Control Act, Act 83 of 1993 be amended to ban advertising and promotion of tobacco products, raise legal age of a child who can buy cigarettes to 18 as well as ban smoking in public places. Subsequently, the Department in collaboration with Cancer Association and Tobacco Action Group stepped up its anti-tobacco campaign by putting anti-tobacco advertisements in 78 radio stations. A study done by the Human Sciences Research Council and the Medical Research Council revealed that 81% of the adults applauded these health warnings while 58% of smokers said that the warnings made them want to quit or change to light cigarettes. Over time, the Department is making a significant impact in tobacco control.

While this is appreciated, it is recommended that a campaign targeting women (particularly black women) should be developed. International trends reveal that lung cancer is increasingly passing breast cancer as the number one cancer killer for women in countries such as Scotland and Northern Ireland. Similarly, research continues to show a link between smoking and health conditions such as heart disease, osteoporosis, pregnancy complications such as low birth weight as well as cancer. For women in their reproductive years, such complications may be compounded by a combination of oral contraceptives and smoking. Undoubtedly, there is more information needed to raise awareness about smoking and associated health risks amongst women.

3.11 Reproductive health services

In restructuring South Africa's health services from a curative to include a community orientation with a specific focus on prevention and health promotion, the Department of Health was well poised to improve health care for women (and children). Women constitute the majority of the population, meeting their health needs therefore becomes a measure of good health practice. Census 2001 shows that there are 44 819 778 people in South Africa. Of these, 23 385 737 (52%) are women with most residing in rural provinces such as Eastern Cape and Limpopo. The latter are not only poor and unemployed; they also have poor access to formal education, a factor that limits their choices in life.

The goal of the Department of Health in relation to reproductive health services is to reduce morbidity and mortality in relation to women. Maternal mortality has been identified by the Department as one of the critical indicators of women's

health, which in turn reflects on the health of the nation. To address this matter, the Department introduced the following strategies:

- Improvement of access to reproductive health services. Such measures include training of fifty-one (51) advanced midwives from seven of the nine provinces. In addition, twenty-one (21) facilitators were trained to assist provinces to start with their own training. Together with the World Health Organization and the European Union, the Department has evaluated the education programme in Advanced Midwifery and Neonatal Nursing Science. The evaluation revealed that the skills of advanced midwives were not fully utilized.[25] Other related strategies entail contraception and termination of pregnancy discussed later in the report.
- Introducing a women's health card which contains information to assist in preventing women's illhealth. Specifically, the card contains information on cancer, violence and rape, termination of pregnancy, STDs and AIDS, TB, pregnancy and contraception, menopause and infertility.
- Improving maternal death notification: In 1997, the Minister announced maternal death as a notifiable condition. Notification was gazetted on 3 October 1997 and commenced on 1 December of the same year. In 1998, data obtained by the Demographic and Health Survey revealed a maternal mortality rate of 150/100 000 life births. [26] The figure itself was viewed as inaccurate because of underreporting as well as initial flaws in the data collection process. For the years 1999, 2000 and 2001, data collection was much more improved resulting in an estimate of 175 -200 per 100 000 live births.[27] The Maternal mortality rate was found to have increased with the following cited as contributing factors:
- Non -pregnancy infections such as AIDS(31.4%), complications of hypertension in pregnancy (20.7%), obstetric haemorrage, including antepartum and postpartum (13.9%), pregnancy related sepsis including septic abortion and puerperal sepsis (12.4%) and pre-existing medical conditions (7%). This category accounted for a total number of 85.4% of all the deaths in the triennium under investigation.

3.12 Other factors were administrative and they included:

- Lack of transport affecting at least 10% of the cases. When considering related factors such as delay in seeking help as well as delays in referring patients, this figure is perceived to be a gross underestimate. Delay in transporting patients between institutions was seen in 13.6% of cases requiring transport.

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25 Department of Health Annual Report 1998

26 Department of Health, 2nd report on confidential enquries into maternal deaths in SA 1999 -2001

27 ibid.

- A lack of health care facilities that includes intensive care facilities, availability of blood transfusions, drugs and laboratory facilities were common administrative factors.
- Lack of appropriately trained staff was also commonly recorded. It was however not clear if the issue was because of lack of training that health care providers did not follow protocol or were there other reasons such as accepted standards for medical and nursing training.

To deliberate and investigate on these matters further, the Minister of Health appointed a task team who made the following key recommendations:

- Guidelines on the management of conditions causing maternal deaths
- Criteria for referral and referral routes
- Improved emergency transport services
- Availability of blood at every institution where Caesarian procedures are performed.
- Distribution of the public sector Termination of Pregnancy services
- Skills in anaesthesia improved at all levels of care
- Promote contraceptive use through education and improved service provision.
- Establish staffing and equipment norms per level of care.
- Counseling and voluntary HIV testing for all pregnant women.

If implemented, these recommendations should result in a significant drop in maternal mortality rate. In her own words, Minister of Health Dr Manto Tshabalala views the report as a challenge "to us as a people and as a health system to respond to the needs of pregnant women…The health system in particular, and society in general, must improve the care of women…As we continue to care for women and children, we must learn from our mistakes, so that tomorrow's women and children benefit from the lessons we learn today."[28] From these words, it is clear that a commitment to reduce maternal mortality should be a collaborative effort between individual women, families, communities, health care providers and the society as a whole. Improving the overall status of women in the society (including working with men) lie at the core of such a commitment.

3.6 Prevention of gender-based violence

Coming from a legacy of racism and sexism, South African society has seen increasing levels of violence. Over the years, many people have died as a result of

[28] Saving Mothers. 2nd Report on Confidential Enquiries into Maternal Deaths in South Africa. 1999-2001

injuries caused by accidental or intentional violence. Whether on the roads, at home, at work or play, the risks to individuals are immense. This means, in addition to political violence, there are many other organized forms of violence such as gang violence, taxi killings, car hijackings, robberies, as well as violence based on race and gender.

Gender-based violence is a serious yet invisible condition that affects women's physical and psychological health. At its most basic, violence against women include domestic violence, rape (including marital rape), incest, sexual harassment, verbal and emotional abuse. A more expansive definition includes forms of institutionalized sexism that compromises the health and dignity of women. Included in this category would be lack of access to safe contraception and abortion as well as sanctions imposed by the church, police, courts of law, educational institutions as well as the medical system as a mechanism of control within a culture that views the female experience as inferior, evil and dirty.

The extent of physical abuse against women in South Africa is unknown because of a lack of accurate and reliable data. It is estimated that every one in four women are regularly abused by their partners. Based on Census 2001 figures, this estimate translates to 5 846 434. With regard to rape, the numbers are equally disturbing.' In 1996, 35 000 were reported to the police in South Africa.[29] Considering that only one in 20 woman is said to report rape, official figures are a gross estimate.

Responding to health care needs of abused women, the Department has included tackling violence against women and children in their five-year objectives. Specific objectives include raising awareness of basic human rights, training health workers in providing a service to abused women as well as developing protocols for the management of survivors of violence against women. In addition, the Department has participated in programmes such as Sixteen Days of Activism on No Violence against women. Currently, work is underway on developing national policy guidelines for the management of survivors of sexual offences.

Training of health workers is critical in addressing a problem which was exclusively perceived as belonging to the criminal justice system. As illustrated in

[29] Country Gender Profile: South Africa 1998
Report prepared for the Swedish International Development co-op
Baden S, Hassim S and Meintjies S.

a study done at Alexandra Health Clinic with a focus on detection of physical abuse of women in a health setting, health workers are well positioned to address this problem. Included in the training should be front line health workers such as Family Doctors (GPs)[30] and emergency room nurses. In the rural areas, training of primary health care nurses in Limpopo has proved to be equally effective.[31] While training is essential, a more inclusive response should involve routine screening for abuse as well as developing treatment plans and formal protocols for dealing with abused women. Equally important is a need to address physical abuse of pregnant women, a factor known to put women at risk to pregnancy complications.[32]

3.13 HIV & AIDS

Fighting the spread of HIV & AIDS has been one of the greatest challenges that the government had to face in the past decade. In 1992, only 112 paediatric cases of AIDS were reported. A few years later in 1995, an annual antenatal survey revealed a 10.44% prevalence rate, a ten-fold increase of infections.[33] In 1997, prevalence rate of infections in antenatal surveys rose to 16.01% [34]up to 24.8% in 2002.[35] In 1997, it was estimated that 7.8 of all adults and 4.3% of the total population were infected. This translated to about 2.2 million, a number that rose to 4.74 million in 2002.

Responding to this challenge, government expenditure increased from 21 million in 1993/94, to 70 million in 1995/96, and 80 million in 1996/7. Despite an increment in government expenditure on HIV & AIDS, it was clear that the overall goal of preventing the spread was not achieved given that new infections were identified to be occurring at a rate of 1000 per day with young heterosexual people being the hardest hit. Concerned with the escalation of prevalence in spite of increasing

30 Motsei M: Breaking the cycle of violence: The role of the family Practitioner SA Family Practice May 1993 208-215

31 Kim J and Motsei M. Women enjoy punishment: attitudes and experiences of gender-based violence among PHC nurses in rural South Africa Social Science & Medicine 54 (2002) 1243 - 1254.

32 Motsei M: Identification of woman battering in health care settings: the case of Alexandra Health Clinic, Centre for the Study of Health Policy, Department of Community Health, University of Witwatersrand, 1993.

33 Department of Health Annual Report, 1996

34 Department of Health Annual Report , 1997

35 Department of Health Annual Report, 2001/2002

expenditure, the Department reviewed its National HIV & AIDS strategy coming with a Government Aids Action Plan developed under the auspices of the InterMinisterial Committee on HIV & AIDS launched by the Deputy President on 9 October 1998. This Action plan contained guidelines on the following:

- prevention of HIV & AIDS amongst young people through life skills programme as well as developing a framework for the implementation of the South African AIDS Youth programme.
- Building partnerships with structures such as faith-based organizations, business and governmental parastatals, labour, media, traditional leaders and Disabled People of South Africa.
- Treatment guidelines in relation to opportunistic infections endorsed by MinMEC in February 2000
- Improved district co-ordination as well as capacity building for primary health care nurse.

Other aspects of the overall plan focused on voluntary testing and counseling, community/home based care, mother to child transmission as well as skills in programme management. In 2001/2, the following were identified as key objectives for prevention:[36]

- establish research sites on prevention of mother-to-child transmission
- strengthen public awareness
- expand effective treatment of STIs

In August 2001, tenders were awarded for mass media campaigns. These campaigns utilized television, radio, print and advertising to create awareness. In addition, the AIDS helpline run by Lifeline under contract to the Department provided telephonic support and provided individualized information and counseling.

As far as treatment care and support programmes are concerned, the government has been heavily criticized for their failure to rollout antiretroviral treatment. While the Department produced guidelines on the use of anti-retroviral drugs in the long-term treatment of AIDS, an absence of these drugs in the health sector proved to be a major obstacle. After a delay, which affected the image of the Department adversely, Cabinet endorsed the report of a joint health and treasury task team charged with examining treatment options to supplement comprehensive care for HIV in the public sector. Subsequently, the Department

[36] ibid.

of Health has recently been requested to develop a detailed operational plan on anti-retroviral treatment plan.

When asked to comment about government's achievements and weaknesses with regard to curbing the spread of HIV & AIDS, women had this to say:

- Educational campaigns (especially radio) are effective but women find it difficult to share the knowledge with their partners for fear of accusations or abuse.
- In the Capricon district, some of the women have never attended an HIV & AIDS workshop. All they know about the diseases is from images in the posters they see on the walls of the clinics when they take their children for immunizations.
- Information acquired from HIV & AIDS educational campaigns (A,B,C) are not easy for women to apply in their daily lives. Women cited factors such as rape (including marital rape), partners refusal to use condoms, extra-marital affairs, migrant labour and poverty as some of the factors that makes it difficult to put theory into practice.
- Teenagers are reported to undermine any HIV & AIDS related advice from their parents as the latter are viewed as "uninformed" or "illiterate".
- Some parents are still reluctant to encourage sex education at school for fear that the children will engage in sex prematurely.
- Educational programmes that bring women and men together were strongly encouraged. It was felt that men are not actively involved in efforts aimed at preventing HIV & AIDS and as a result, the burden lies on women in their roles as lovers, wives and mothers.
- Local support to be strengthened by targeting community initiatives such as stokvels, burial societies, and religious women's groups.
- Quality of free condoms distributed by the Department was questioned. There was also a prevailing misconception that these condoms cause disease.
- There is a strong criticism on the fact that many of the workshops happen in the urban areas in English. This makes it difficult for people to understand the content of the messages.
- A lack of strategy for special groups such as deaf and blind was raised.
- Lack of treatment in public services was seen to be a major obstacle. A speedy rollout of anti-retrovirals was recommended.

3.14 Cancer control

In 1992, the National Registry of South Africa reported 25 894 male cancer cases and 25 413 female cancer cases.[37] The figure does not elaborate on whether female cancer cases had female cancers such as cancer of the cervix or breast or whether they have other cancers such as cancer of the stomach or lungs. In 1992, cancer of the cervix was cited as the most common cancer among women with 4 467 new cases. Of these, 3 390 (75.8%) affected black women, a figure reported to rank the highest in the world.

By the year 2001/2002, cancer of the breast was reported to have overtaken cancer of the cervix as the most common cancer among South African women. In response to these, the Department of Health developed National Guidelines on screening of cervical cancer offering three free pap smears every ten years to women over 30.[38] In addition, Breast Cancer Awareness Month was created in October, an event that has become a major event in the health calendar with private and public institutions working together. Media coverage generated by the Department of Health on breast cancer during the year 2001 amounted to about R 1.49 million in publicity value.

To measure the impact made, women in the review groups were asked a question specifically about their awareness of cancer of the breast and cervix. Many of them, (rural and urban) were not aware of the policies on prevention of cancer. In exception to a local health facility Kwagga Extension 4, Ekangala District in Mpumalanga, which was reported to offer cancer-screening facilities, many of the women reported a lack of such a service in their areas. Women in Ekangala were satisfied with the service especially the information offered by local health promoters in their home visits.

Recommendations given by these women included:

- Awareness training on cancer of the cervix for traditional healers. Many women still consult traditional healers when affected.
- More awareness for women in their local languages. It was recommended that the use of local radio stations would be of benefit.
- Education to target older women to counter the prevailing misconception that cancer affects younger women.
- Expand services in rural-based health facilities.
- Train health workers not only in how to do a Pap smear but also in being sensitive to a woman's genital area. Whether performed by female of male health workers, a

[37] Department of Health Annual Report 1997

[38] Department of Health Annual Report 2001/2002

gynaecological examination is often accompanied by physical and psychological discomfort, which could be exacerbated by the health workers attitude to a woman's body.

4 ACHIEVEMENTS AND CHALLENGES

Soon after the first democratic elections in 1994, South Africa emerged as an active player in global development issues. The first step post-1994 was to participate in Beijing preparatory activities. After being isolated from the rest of the continent for decades, South African women met in Dakar, Senegal on 16 -23 November 1994 to adopt an African platform of Action. This was followed by participation in the Beijing Platform of Action. Among the commitments which the government made post-Beijing includes addressing women's experience of poverty, violence, negative attitudes to womanhood as well as their lack of power (and choice) over their sexual and reproductive lives.

Following Beijing in 1996, the Special Rapporteur on Violence Against women visited South Africa at the invitation of the government. The main purpose of the visit was to investigate the issue of rape in South Africa. While the report raised various concerns largely in relation to the Criminal Justice System, the report also concerned itself with the role of the District Surgeon in responding to sexual abuse. It was reported that most district surgeons did not receive specialized medical training essential to examine and treat victims of rape. Despite useful crime kits provided by the government, the rapporteur was concerned that medical students do not have specific training for examining victims of sexual violence. Responding to the contents of the report, the Department of Health embarked on measures aimed at developing guidelines for health worker training.

In December 1995, a few months after South Africa's first official participation in a UN Nations conference, government ratified Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW). Prior to that, in August 1995, South Africa celebrated its first National Women's Day on 9th August. While all CEDAW articles have an indirect impact on women's health, article 12 calls specifically for equal access to health care while article 14 calls for attention to the plight of rural women. Immediately following ratification, South Africa prepared and presented its first report to the Committee on the Status of Women.

At a regional level South Africa was a signatory to the Gender and Development SADC Declaration signed by Heads of State on 8th September 1997 in Blantyre, Malawi. A year later, SADC Declaration on the Prevention on Violence Against women and children was signed on 14 September 1998 in Mauritius. Nationally, the National Machinery on Gender Equality, including the Office on the Status of Women, Commission on Gender

Equality and Gender Focal Points were set up followed by National Policy Framework for Women's Empowerment and Gender Equality. At Departmental level, the Department of Health was instrumental in developing policy guidelines for gender mainstreaming.

As far as Human Resource Development is concerned, the Department embarked on a strategy of increasing the number of women in decision-making positions within health care. As of 1999/2000, women constituted 58.8% of the workforce in the Department with the majority concentrated in junior management (68.6%) as compared to middle management (31.9%) and top management (31.9%).[39] The Department remains committed to correcting racial and gender imbalances at top and middle management. As far as the categories of health workers are concerned, nurses form the majority of health workers. Their encouragement and support to further training in management positions lends itself to empowerment of women within the health care sector. As a way of encouraging and rewarding health workers who walk an extra mile, the Department has created awards for excellence in district health development and nursing. The national Cecilia Makiwane Award was run for the first time in 2001/2002. [40]

At policy level, the South African government walked an extra mile in creating institutional and policy frameworks for gender equality. Mainstreaming of gender, however, is not an event but a process. Recognizing challenges that comes with gender mainstreaming Minister of Health, Dr Manto Tshabalala-Msimang noted in the Policy Document that in many instances

> "gender issues have not been considered in the process of policy development and service implementation. The result has been that the ability of the service to address widespread gendered problems such as violence against women remains limited. The understanding of health workers of how gender norms affect their clients'health and health seeking behaviour is also limited hence their responses and treatment may well be ineffective."

From the foregoing, one can deduce that the next steps involve education and training of health workers on gender planning, implementation and evaluation as well as raising awareness on the negative impact of sexism on the nation.

Overall, addressing gender imbalances in health hinges on measures aimed at addressing discrimination of women at all levels including promoting equality at executive political and government level, equality in education, family and working life. This means

[39] Department of Health Annual Report 1999/2000

[40] Department of Health Annual Report, 2001/2002.

addressing occupational health services must consider specific ways in which a working woman is affected both in a private and public sphere. In the end, it is the representation of women in various decision-making bodies as well as gender sensitization of men that will make a difference in creating a culture that fosters and makes room for women's participation in development. In the past decade, the South African government has made major inroads in this regard.

When asked to list the Department of Health's achievements for the decade, women who participated in the focus group discussions identified the following:

- Provision of free health care services
- Primary School Nutrition Project
- Improved accessibility of health facilities including mobile clinics.
- Emergency services - response by ambulance services reported to have improved in the Blouberg area, Capricorn district, Limpopo Province.
- HIV/AIDS education - government has done well in educating communities. Poverty and lack of treatment were however identified by women as major obstacles.

It is clear from the above that the Department of Health has come a long way in addressing health concern affecting women. A lot has been achieved, institutional and legislative framework has been established. The greatest challenge remains implementing new laws and policies as well as mobilizing resources (human and financial) for this task. A partnership between government and civil society will go a long way in making the dream of health for all a reality. Strengthening women's participation in all sectors of public and private life remains at the core of this dream.

When asked a question, "Where to from here?" on a television panel celebrating Women's Day 2003, Advocate Mojanku Gumbi, legal advisor to the President and women's rights campaigner responded: "There are no limits for women in South Africa". Indeed.