Gender-Aware Policy and Planning: A Feminist Analysis of Aspects of the Mental Health Care Bill, 2000 and the Skills Development Act, 1998

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CONTENTS

Page

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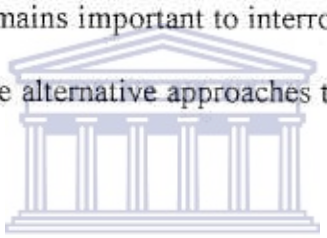
ABSTRACT

In South Africa, government health and social development policy impacts differentially based on gender. The implications of gender impact therefore need to be prioritised in the policy making-process if policy hopes to be equitable, appropriate, effective and sustainable. Although the legislative framework in South Africa creates an enabling environment in this respect, many key players in the policy process approach gender in problematic ways (e.g., gender-blind, "add-on", and "women and children" approaches). At best, these approaches reflect a lack of understanding gender and the implications of failing to reach the goals outlined above. At worst, they reflect a lack of commitment to achieving gender equity. Hence, it remains important to interrogate dominant approaches to gender and policy, and to formulate alternative approaches towards realising equitable policy.



This thesis aims to explore a gendered policy analysis approach to government health and social development policy. Two policies are selected for analysis: the Mental Health Care Bill, 2000 and the Skills Development Act, 1998. The Bill and the Act exemplify types or categories that appropriately accommodate a gendered approach to policy analysis - the Bill represents a generic health policy (a framework for mental health policy), and the Act represents an intersectoral social policy. The Bill and the Act are analysed separately primarily drawing on the gendered theorisation of local authors. The methodological approach thus embodies an approach to policy analysis that argues for impact of context, actors, problem identification, solution development, political process, content, power and, crucially, gender.

Secondary sources or data (e.g., reports, submissions to Parliament, minutes of Portfolio Committee meetings, other relevant documents) and a survey of key informants involved in the policy-making process are also used to substantiate the analysis. An open-ended questionnaire was sent to 24 informants who were in a position to answer questions in regards to mental health or skills development policy and gender. A gender-blind approach to policy by key policy-makers emerged as a central "theme" of the analysis. Related to this approach, other important issues to emerge include community-based care (i.e., "women-based" care), gaps in regards to women's sexuality and gender-based violence, and token representation for women on structures and the ways in which this reinforces the status quo in legislated structures.

The main implications for a gendered policy analysis from this study are that: (1) Gender equity is not something that automatically occurs in the implementation of policy because a rights-based approach to gender is adopted in the policy process. It is also necessary to concurrently be aware of and to develop and implement policy that consciously strives to change the power imbalances between women and men. (2) Where health and social development policy and legislation does not take account of the differential gender impact, the implications are likely to be substantial for South African society as a whole.

Recommendations for the policy-making process and suggestions for future research in this thesis are aimed towards promotion of equitable health and social development policies, and also to help promote gender equity in the broader South African legislative framework.

CHAPTER ONE
INTRODUCTION

BACKGROUND AND RATIONALE

The Constitution of the Republic of South African (Act No. 108 of 1996) came into effect on 4 February 1997. The Constitution is the supreme law of the land, and all policies and laws are meant to be consistent with the principles, rights and rules of the Constitution. The Bill of Rights in the Constitution (Chapter 2) sets out the rights that are meant to promote and protect important values for building and sustaining democracy in South Africa (PHILA, 1999). These values include human dignity, equality and freedom for all South African citizens. The Constitution and especially the Bill of Rights provides a framework to promote gender equality in South Africa. This includes the promotion of gender equality in the health and social development sectors. For example, the Bill of Rights provides that:

> The state may not unfairly discriminate directly or indirectly against anyone on one or more grounds, including race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language and birth. (Constitution of the Republic of South Africa, 1996, Bill of Rights S9(3), p. 7).

Other provisions in the Bill of Rights which impact on equality in health and social development include reproductive rights, access to health care, safe environment (not hazardous to health), food, nutrition, and social security which includes appropriate social assistance. The Bill of Rights provides for the right to "bodily and psychological integrity" (S12(2), p. 8) and for the right "to security and control over one's body"

(S12(2)(b), p. 8). Moreover, every person has the right to both "basic education...and further education" (S29(1)(a)(b), p. 14) which the state "through reasonable measures, must make progressively available and accessible" (S29(1)(b), p. 14).

The Constitution also provides for the establishment of a number of parliamentary structures commonly referred to as "national gender machinery" (Friedman, 1999). The structures are the Commission on Gender Equality (CGE), the Office on the Status of Women (OSW) and the Joint Monitoring Committee on the Improvement of Quality of Life and Status of Women. These bodies are mandated to, amongst other things, expose gender discrimination in government policy, and influence, monitor and evaluate the impact of policy on women. The African National Congress (ANC) Women's Caucus and the Parliamentary Women's Group are two further important informal structures. According to Friedman, the latter is a central point of access for advocacy by civil society.

The South African Human Rights Commission is another commission that strives to make an effective contribution to gender justice in South Africa. In addition, many government ministries or departments have a gender desk or unit. There are also non-governmental organisations such as the Women's Health Project (WHP), Gender Advocacy Programme (GAP) and the Women and Rights Project, Community Law Centre, University of the Western Cape, which monitor policy, make submissions to Parliament on proposed Bills, and generally play an important role as advocates for gender to be an integral element in all government policy.

According to de la Rey and Kottler (1999), policy development in South Africa is in itself another important arena of progress on gender equality. For example, de la Rey and Kottler say that there are moves towards formulating a national policy on gender. They argue that this advance is due to recognition by policy-makers of the lack of a coherent national strategy on gender. Maharaj (1999) also points to gains for gender equality made through the policy-making process in South Africa. She refers to a report commissioned by the Commission on Gender Equality[1] that suggests that women have made legislative gains in the Recognition of Customary Marriages Act (No. 120 of 1998), the Employment Equity Act (No. 55 of 1998), the Adoption Matters Amendment Act (No. 56 of 1998), the Domestic Violence Act (No. 116 of 1998), and the National Water Act (No. 36 of 1998).

De la Rey and Kottler (1999, p. 121) also note other ongoing strategies "which seek to ensure that gender equality is not simply a matter of documentation but a de facto reality". One such strategy is the Women's Budget Initiative, a collaborative initiative between non-governmental organisations, research institutes, and a national parliamentary committee on finance, which seeks to

> [track] expenditure on women through the budget allocations and...find creative and rigorous ways to value the economic and social contribution of women. The objective of this project is to stimulate and support the integration of gender into planning, budgeting and expenditure. (de la Rey & Kottler, 1999, p. 121).

[1] Centre for Applied Legal Studies' Gender Research Project. (1999). "Audit of Legislation that Discriminates on the Basis of Sex/Gender".

Parliament (since 1994) within this enabling framework has promulgated myriad health and social development policy, including White Papers, Policy and Discussion Documents, Bills, Acts, Amendments and Regulations. It is unclear, however, what the current gender impacts of these policies are or what the future impacts are likely to be. Moreover, it is unknown in what ways government policy impacts on poor and marginalised women. An assessment in this regard needs to be conducted. Such an assessment would have to take account of the ways gender, race, class, and age and current political, economic, and social policies interweave and impact on the effectiveness of social policy (Baden, Hassim, & Meintjes, 1998).

The Need to Focus on Impoverished Women

At the Hearings on Poverty (SANGOCO & CGE, 1998), gender emerged as one of the important factors that compound people's vulnerability to poverty and undermines their well being. Unemployment as a theme recurred most often at the hearings, and is a particular problem in rural areas. In 1995, about half (44%) of South Africans were poor, nearly 95% of poor people were African, and the vast majority (75%) of the poor lived in rural areas (Friedman, 1999). Further, female-headed households had a 50% higher poverty rate than male-headed households, unemployment was rife, and fewer than 30% of poor working-age adults were working.

In terms of priorities for change, employment is the major priority (57%) for the poor SANGOCO & CGE, 1998). This is followed by water (44%), food (34%) and housing (32%). In terms of health impacts, more than half of the poor is unable to get treatment

because of high costs of treatment or transport. In all age groups, unemployment is higher for women than for men; and four in ten economically active women between 15 and 30 years are unemployed (Newton, Orr, Volodia, & Budlender, 1999).

Stein (1999) reports on research conducted by the Department of Health into maternal deaths in South Africa. According to the study "Saving Mothers: Report on Confidential Enquiry into Maternal Deaths in South Africa, 1998", South African women are dying unnecessarily while in labour. One hundred and fifty women die in the process of giving birth for each 100 000 babies born alive. This maternal mortality ratio is the best in Africa, but is 12 times higher than in developed countries. The report concludes that the women are dying because it takes too long for their local clinics to refer them to hospitals or because they lack transport to get to hospital in time.

In terms of mental health, evidence suggests that the quality of a person's social environment influences both her or his vulnerability to mental illness and the course of that illness (WHO, 1996). Poverty, overcrowded living conditions, job insecurity, violence against women, children and the aged, wars - all of these impact negatively on mental health. The most common mental health problems in South Africa are "expressions of the trauma of living" - depression, anxiety, alcohol use, interfamilial problems, and conflicts (Strachan & Clarke, 2000).

A study conducted in 1991 in Khayelitsha cites the high prevalence of psychological distress, depression and limitation of activity among newly settled elderly residents

(Gillis, Welman, Koch, & Joyi, 1991). Moreover, the highest levels of psychological distress and depression were found amongst the elderly women. The study suggests that adversity and situational stress, especially poverty, significantly contributed to the high level of psychological distress amongst the women. Other important contributing factors include extremely poor accommodation, a particularly low level of access to education and to pensions, unfamiliarity with services, and the extra stress for the women linked to their status and social role in society.

Strachan and Clarke (2000) suggest that the impact of poverty on mental health is high in South Africa because of the wide prevalence and severity of poverty in the country. They further suggest that the situation is exacerbated by the inability of the health services to deal appropriately with mental health problems; the stigma attached to persons with mental health problems (evidenced by, for example, many health providers' negative attitudes towards them); and the disparity of services between provinces. Improved economic status and living conditions; improved capacity in the health system, especially at primary care level; and destigmatisation are all possible ways to decrease the prevalence of mental health problems.

Moreover, large groups of South Africans are systematically disadvantaged by the mental health services dispensation that was inherited from the apartheid government (Flisher, Fisher, & Subedar, 1999). Included in these groups are women, rural dwellers, the poor, and those in poorer provinces. Inequities along gender and racial lines were examined and reflect gender and racial inequities in South African society.

In terms of gender and labour in South Africa, it is strongly suggested that women are traditionally discriminated against in the workplace (Presidential Commission, 1996). Issues which affect women include: exclusion from certain types of jobs, inadequate provisions for childcare, lower wages for work of equal value, inadequate maternity benefits and sexual harassment. African women aged between 16 and 24 living in a rural area have the highest probability of being unemployed. Further, particularly black women wage earners are clustered in the lowest paying sectors and occupations. Social relations are the products of historical processes of conflict and change; they cut across different sectors of society - economic, cultural, political, psychological (Mbilinyi, 1993).

Unemployment rates are generally higher for women than for men. Amongst African women, up to 50% of those who want jobs cannot find them (Presidential Commission, 1996). Approximately 19% of regularly employed women were working in the extremely low-paid domestic service sector. Thirty-one percent of all regularly employed African women were domestic workers in 1993. Even where women are in the same jobs as men, or in jobs accorded similar value, women workers are still paid less than male workers are. The statistics on enrolment in training programmes shows a continued and increasing bias against women and Africans. There were no female apprentices in the food processing sector, women made up just 2.4% of apprentices in paper and printing, and comprised 3.5% of apprentices in metals and engineering. Moreover, only 23% of enrolees in non-apprenticeship job training programs were women.

Women generally earn less than men do due in part to working in different sectors, doing different work, and because women's work usually has lower status than men's work (Newton et al, 1999). For instance, in 1997 80% of employed women worked in "elementary" occupations that require very little skill. Of these women, 45% were African women.

Despite the above, it appears that there is a lack of systematic research into the gender impact of health and social development policy and legislation promulgated in South Africa since 1994. Yet, it is clear that there is an urgent need to address these issues, especially in regards to the ways in which the policy process impacts on impoverished and marginalised women. The worldwide phenomenon of the feminisation of poverty makes an exploration of these issues seem particularly appropriate.

AIMS OF THE STUDY

This research analyses from a feminist perspective two pieces of South African government policy[2] - the Mental Health Care Bill, 2000 and the Skills Development Act (No. 97 of 1998) - which are representative of health and social development policy post-1994. The implications and potential impact the Bill and Act have for gender are explored. In conducting the analysis, the researcher draws on the theoretical conceptualisations and policy analysis frameworks of several writers, notable of which are Klugman (1999), Friedman (1999), de la Rey and Kottler (1999), and de la Rey and Eagle (1997). The main aim is to address the question of the impact of specific

[2] "Government policy" is used in this study to connote government policy documents, bills, acts, regulations.

government policy on poor and marginalised women. In this process, important questions explored include:

- What assumptions are built into the Mental Health Care Bill and the Skills Development Act, especially those that involve and will impact on poor and marginalised women?
- What are the probable short-term and long-term effects of the Bill and the Act on poor and marginalised women?
- How will the outcome of the Bill and the Act be evaluated?
- What changes should be made so that the Bill and the Act are more responsive to poor and marginalised women?

The researcher is currently working as a policy analyst for PHILA (Public Health Interventions Through Legislative Advocacy), a national programme of the NPPHCN (National Progressive Primary Health Care Network). PHILA focuses on policy analysis of health and social development legislation, and capacity building of members of provincial legislatures (MPLs) on provincial Standing Committees on Health. PHILA has identified a crucial gap in their work: The capacity to analyse the impact of health and social development policy and legislation on women. More important, this seems to be typical of NGOs working in the health policy arena. This research could therefore help to address a lack of attention to gender in the NGO sector. Furthermore, with PHILA's work with MPLs, this research could also be influential for policy-makers at provincial level.

Health and Social Development Policy

At this point a digression is necessary in order to provide a brief explanation of the Mental Health Care Bill, 2000 and the Skills Development Act, 1998. Please note, however, that a more detailed summary of the Bill and the Act is provided in Chapter 3.

Mental Health Care Bill, 2000

The Mental Health Care Bill, 2000 is the latest version of the Bill (draft 4). The Bill constitutes a re-write of the Mental Health Act, No. 18 of 1973. Mental health issues are part of the broader agenda for transformation of the health sector. The Bill moves towards a health rights approach to mental health care, which represents a dramatic change from the hospital-based custodial or preventive model of care sanctioned by the 1973 Mental Health Act. The draft Bill is likely to be submitted to Cabinet in early August and, if approved, thereafter to the Portfolio Committee on Health. It is likely that public hearings and submissions on the Bill will be held. The Minister of Health hopes to table the Bill in Parliament by the end of this year.

Skills Development Act, 1998

Post-1994, the Department of Labour embarked upon a national skills development strategy in a bid to increase the level of skills in the country. The Skills Development Act of 1998 and related legislation[3] are the laws that reflect and concretise this strategy. Government's intention with the legislation is to increase the level of skills in the country, currently perceived to be unacceptably low. According to government, the low level of skills places constraints on economic growth and on employment prospects, which are reflected in high levels of unemployment. The new legislation is an attempt to address these constraints and challenges.

[3] The related legislation include the Skills Development Levies Act, No. 9 of 1999; the Skills Development Levies Act, 1999: Regulations Regarding Levies and Related Issues; the Skills Development Act, 1998: Regulations for the Period 1 April 2000 to 31 March 2001 Regarding the Funding and Related Issues; Draft

CONTEXTUALISING THE THEORETICAL FRAMEWORK

The theoretical framework of this study is contextualised in this section. However, prior to doing this, it is pertinent to briefly explain the term *gender* and how it differentiates from the term *sex*; and to define the concepts *mainstreaming gender*, *gender equality* and *gender equity*.

Explanation of Terms

According to the World Health Organisation (1998), *gender* refers to the differential socially determined position of women and men in societies. It is related to how we are perceived and expected to think and act as women and men because of the way society is organised, not because of biological differences. *Sex* refers to the genetic/physiological or biological characteristics of a person that indicates whether one is female or male.

Mainstreaming gender means an integration of gender concerns into the analyses, formulation and monitoring of policies, programmes and projects, with the objective of ensuring that these reduce inequalities between women and men. *Gender equality* is the absence of discrimination on the basis of a person's sex in opportunities and the allocation of resources or benefits or in access to services. *Gender equity* refers to the fairness and justice in the distribution of benefits and responsibilities between women and men. It recognises that women and men have different needs and power and that these differences should be identified and addressed in a manner that rectifies the imbalances between them.

Regulations for Learnerships and Skills Programmes; the Skills Development Act, 1998: Regulations with Regard to Private Employment Agencies.

Williams, Seed, and Mwau (1994) note that gender is a dynamic concept. They suggest that race, class, culture, social group, economic circumstances, and age all influence what is considered appropriate roles for men and women. In addition, these authors note that "as culture is dynamic, and socio-economic conditions change over time, so gender patterns change with them" (p. 4).

In South Africa, language and discourse on "gender" is complex and can be confusing (Friedman, 1999; de la Rey & Eagle, 1997). Examples of commonly used terms include *gender equality* (as in the Constitution); *gender-sensitive policies and programmes* (as in the mission statement of the OSW); *mainstreaming gender*; *integrating gender*; *women's empowerment*; and *gender transformation* (Friedman, 1999). Difficulties arise, argues Friedman, when gender language is used in ways that "mask the complicated ways in which gender relations intersect with social relations of class, 'race', age, geography, ethnicity and sexuality" (1999, p. 11). Within this context, it is possible that, as Meer argues (1999, cited in Friedman, 1999), gender has become depoliticised as a concept. Still, as Friedman points out, gender discourses, and particularly the meaning of gender equality, are constantly being reformulated and redefined; and policy-making discourse and practice are central sites of that process.

In sum, then, gender can be conceptualised as largely relationally defined and constituted in a way that embodies different power interests and constructions (de la Rey & Eagle, 1997). These authors argue that the terms *gender equity*, *gender equality* and *non-sexism* are often used interchangeably, leading to "conceptual confusion". While acknowledging

that there is no consensus on the debate, they favour the term *gender equity* because it "incorporates both the empowering of women and the dismantling of male domination in society" (1997, p.155). In this paper, references to the implications for gender equity of the policy process are conceptualised using the latter understanding of the term.

It is also appropriate for this study to pay attention to the ongoing debates related to the Women in Development (WID), Gender and Development (GAD), and Women and Development (WAD) theoretical approaches. These debates are particularly relevant in terms of exploring the social development impact of the Skills Development Act.

Women in Development (WID), Gender and Development (GAD), Women and Development (WAD)

Women in Development (WID) is a liberal modernization approach which seeks to analyse the barriers women encounter in accessing and participating in social institutions, including education, training and the workplace. This approach is concerned with identifying ways of overcoming barriers to access and bringing women into modern institutions which are viewed as unproblematically beneficial for women and are often identified as the source of their emancipation (Chisholm & Unterhalter, 1997).

Empowerment for women in WID literature is usually defined in terms of "power to", which refers to decision-making abilities at the household level (Masika & Joekes, 1996). The "power over" notion of empowerment, on the other hand, relates to collective actions and power over social structures and institutions.

WID policy and practice is also seen as remaining grounded in the assumption that women need to be integrated into the development or modernization process (Parpart, 1995). "Sacred cows", such as the accepted division of labour, and traditions which reinforce women's subordination to men are "reified as culture, and therefore placed outside the development mandate" (1995, p. 228). Moreover, most development plans ignore the need for fundamental social change in gender relations and the possibility that women might organise to fight for this. The discourse of various WID documents on women living in the third world women perpetuates an image of them as a homogenous group of backward, traditional powerless victims. Moreover, women are assumed to be a coherent group or category prior to their entry into the development process (Mohanty, 1991a).

WID fails to make a substantial and sustainable positive impact on the lives of the women it targets, which is underpinned by simplistic formulations that make ahistorical, universal assumptions about women and men (Mohanty, 1991a). Women are lumped together as an undifferentiated group based on their supposedly common subordination. This conceptualization strengthens a dichotomous notion of power (men have power/women have no power), but simultaneously weakens the combating of oppressions. In other words, women as a group are defined as subjects outside social relations, rather than as constituted through these structures. Development policies and plans not only often reflect this anomaly, they consistently perpetuate it by not being able to accommodate the multiplicities of women's identities and realities.

Chowdhry (1995) suggests that the power of the WID discourse is largely due to it being made up of the two distinct yet overlapping strands of colonial discourse and liberal market-oriented discourse, which is particularly pernicious for poor Third World women. Nzomo (1995, p. 137) argues that national and international development planners and aid agencies are notorious for their tendency to lump especially third world women together as a group, usually with negative connotations such as "*poor* and *vulnerable* [which is] misleading and patronizing" (emphasis in the original).

WID also has a tendency to reduce the experiences and lived realities of people into a set of tidy economic statistics or technical jargon (Mohanty, 1991a; Zwart, 1992), where "variations between rich and poor are submerged in a sea of negative numbers" (Parpart, 1995, p. 229). Economic development policies are used simplistically as a measurement of development outcomes - women are either affected positively or negatively, and development "becomes the all-time equalizer" (Mohanty, 1991a, p. 63). WID's approach to development is further depicted by critics as increasing women's workloads, reinforcing inequalities, and widening the gap between men and women due to its efforts to increase women's efficiency in their existing roles (Williams, Seed, & Mwau, 1994). WID endorses the establishment of separate structures for women both in government and NGOs which results in marginalised, "add-on" policies, programmes and projects aimed specifically at women (Levy 1990, cited in Pandy, Watson, & Makan, 1997).

The concept of development is contentious not only for what it contains, but also for what it excludes, such as "the possibility that people may perceive 'progress' or 'development'

very differently from policy makers" (Udayagiri, 1995, p.160). Udayagiri's analysis is important in that it shows how various development discourses, such as those of WID and GAD, can be subsumed under the rubric of political discourses which, to a greater or lesser extent, legitimize mainstream definitions of modernization and development.

Gender and Development (GAD) draws on feminist critiques of liberal modernization and poses questions about gender relations within institutions once access to them may have been attained (Chisholm & Unterhalter, 1997). An emphasis on exclusively women is replaced by one analyzing shifting boundaries and relationships between women and men and the ways in which the gendering of institutions, or social relations between women and men, shape institutional power relations and unequal outcomes for women. The connections between gendered sites such as the family, the state and the labor market has been another strand of such research

When GAD emerged as a potential alternative to WID it was hailed by some feminist researchers as a fundamental shift from the liberal paradigm, particularly where it underscores the socially constructed nature of gender and is attentive to gender relations between women and men (Orner, 1999). Others, however, often coming from a postmodernist perspective, perceive GAD as deeply embedded in both modernity and Western feminism (Udayagiri, 1995). For these critics, then, the GAD approach suffers from a tendency to essentialise third world women by lumping them into an undifferentiated group of passive, powerless victims, while women in the first world are, in contrast, supposedly liberated. Yet, there are other feminist theorists, amongst whom

Udayagiri positions herself, who argue for a more nuanced critique of WID/GAD. They question the tendency of some postmodernists' claims to the moral high ground while simultaneously rendering other social critiques of development obsolete.

The Women and Development (WAD) framework is seen as an alternative to a reformist WID approach (Levy, 1990, cited in Pandy, Watson, & Makan, 1997) and is underpinned by the concept of empowerment, articulated by third world women since the 1970s (Pandy, Watson & Makan, 1997). Unequal gender relations are recognized within this approach not only as a problem with men, but also of colonial and neo-colonial oppression. Third world women acknowledge that they need context-specific development approaches which take into consideration issues of class, culture, ethnic diversity and gender.

However, WAD is perceived by Zwart (1992, p. 16) as "merely a refined and more critical version of the WID concept". Both the WID and WAD perspectives, Zwart argues, do not address the underlying problems of class and gender inequality (and on a larger scale the inequality between the North and the South), and this explains why their initiatives often fail. Moreover, the WAD approach "tends to analyse women as a homogeneous group, taking little notice of important differences of class, race or ethnicity" (p. 16). Zwart suggests that, in contrast, the GAD strategy questions traditional views of gender roles and responsibilities and then tries to develop strategies that lead to empowerment. Central to these strategies is that women are seen as agents of change, rather than as passive recipients of development assistance.

OUTLINE OF CHAPTERS

Chapter 1 is the introduction of the research topic. Background information to the topic is provided. The rationale and the aim for the study are stated. An outline for each chapter of the thesis is provided in this chapter.

Chapter 2 expands on the issues raised in Chapter 1 by reviewing the literature on the policy-making process and on policy analysis frameworks or models. A main section of the chapter focuses on policy analysis frameworks that are particularly relevant for this study. The chapter concludes with a discussion on the reasons for adopting an approach to policy analysis which places gender as pivotal to the analysis. This approach is then used in Chapter 4 to analyse the Mental Health Care Bill, 2000 and the Skills Development Act, 1998.

Chapter 3 provides an explanation of the methodological approach used in this study.

In Chapter 4, the Mental Health Care Bill, 2000 and the Skills Development Act, 1998 are analysed. Firstly, there is a summary of the Mental Health Care Bill, focusing on main objectives of the Bill. This is followed by an analysis of the Bill. Next, the Skills Development Act is summarised, focusing on main objectives, followed by an analysis of the Act. The analysis is based on the data obtained from the documents and interviews described in the section on Methodology. The main focus of the analysis is on gender. The analysis is informed by the theoretical conceptualisations on the policy-making process and on policy analysis frameworks discussed in Chapter 2. In particular, the

analysis is underpinned by gendered conceptualisations of the policy-making process and policy analysis.

Chapter 5 highlights the links between theory and the important issues emerging from the analysis of the Mental Health Care Bill and the Skills Development Act in Chapter 3. The focus of the chapter is on implications for gender specifically in regards to the Bill and the Act, but the implications for gender and the policy process more broadly are also a central focus. The chapter highlights a critical need for a gendered policy analysis.

Chapter 6 provides reflection on the original questions asked at the outset of the thesis, as well as recommendations and suggestions for further research on the topic of engendering policy analysis.

CHAPTER TWO
POLICY, POLICY ANALYSIS, GENDERED POLICY ANALYSIS

This chapter further explores the implications of the issues raised in Chapter 1. It starts off by reviewing the literature on the policy-making process. It goes on to discuss policy analysis frameworks which are particularly relevant for this study. In this respect, gendered policy-analysis frameworks are highlighted. This exploration frames and provides an introduction to the central argument of this thesis - the need to adopt a gendered approach to the policy-making process.

WHAT IS POLICY?

Policy is a statement of intent, or a purposive course of action or intervention (Leonard & Thomas, 1998) followed by an actor or set of actors in dealing with a problem or matter of concern (Walt, 1994). It is a series of more or less related activities and their intended and unintended consequences for those concerned. Public policies are policies developed by governmental bodies and officials, and focus on purposive action by or for governments. Policies are also seen as governmental or organisational guidelines about allocations of resources and principles of desired behaviour, which are affected by multiple competing forces (Trostle, Bronfman, & Langer, 1999).

Policies should represent what governments say they will do, what they actually do, and what they decide *not* to do, given that choosing not to do something may represent a policy (Walt, 1994). The development of public policies (the identification of a problem and proposed solutions to it) requires an analysis of how a problem gains recognition as a

problem to be addressed in the political terrain (Klugman, 1999). Just as important, is consideration of how specific solutions get on the political agenda, and why politicians are concerned with certain issues rather than others at particular times.

The attributes of policy include intention, action, practice, status, resources and capacity, and power (Czerniewicz, 1998). It is usually directed towards the accomplishment of some purpose or goal. The distinction between policy and decision is often blurred; but policy is larger than decisions. Policy usually involves a series of specific decisions, and policy is always affected by past policies (Walt, 1994). Many writers do not distinguish between policy and planning, but Walt sees planning essentially as following policy. For example, planners help to put policies into practice.

Policy is never static, but continuous, ongoing and interactive, and unstable. It is characterized by a compromise of ideas, needs, and interests; and it is always located in contexts of time and place (Czerniewicz, 1998). The policy process does not begin and end with policy formulation: "It extends into the policy implementation arena where policy intentions are interpreted and re-interpreted" (1998, p. 13).

Policy communicates that which a society values, although consensus on values is often elusive. Nevertheless, values, interests, politics and power are integral to the notion of policy and the attempt to understand what it means (Czerniewicz, 1998). Policy provides guidelines for daily actions and decisions for organisations and institutions; embraces a broad sphere of governance; and confers predictability on the process of government. It provides a basis on which to foresee outcomes and a yardstick for evaluating the

performance of public institutions. Czerniewicz argues that in times of transition (such as the current situation in South Africa), it is important to look at: (1) the ways in which one policy is framed by other policies; (2) contradictions that emerge between policies; (3) the potential policies have to influence one another; and (4) the lack of coordination in policy formulation in different sectors.

Czerniewicz (1998) stresses the central and interdependent role of resources and capacity in the policy process. By resources, she refers to both physical and human resources; and by capacity, she points to *existing* human skills, and to infrastructure. Attention to resources and capacity includes an understanding of the impact they have on whether policies *do* get made and *how* they get made; as well as understanding the link between policy formulation and implementation breakdown. Resources are not only unstable, they are especially vulnerable to sudden shifts often due to unforeseen or unprepared for crises.

The State and Policy

The political system of a country is "an abstract notion of many forces which impinge upon the state (another abstract idea) and government" (Walt, 1994, p. 15). Thus, it encompasses the state, government, the private sector, political parties, and individual voters, and provides the framework that determines the policy-making process, including the extent to which the public participates in the policy process. The state itself comprises all authoritative decision-making institutions in society including all government bodies (e.g., parliament, the executive, the bureaucracy, ministries or departments of state, local authorities, the armed forces, the courts of law), as well as the functions that they

perform. The state is legally supreme and can use coercion to achieve its ends. In terms of policy, Walt notes that the state is concerned both with domestic policies and with international policies. There appears to be consensus amongst policy analysts that a *reformed* state must continue to have the central role in the policy making process (Walt & Gilson, 1994).

The concepts of the state and government are often used interchangeably, but government is a narrower concept and, in essence, subsumed by the workings of the state. Government includes the public institutions - such as parliament - in which collective decisions are made into law (Walt, 1994). Government policy can be seen as the practical expression of political interests and ideals applied to national challenges and problems. The complexity of the process means that people in government deal with such issues as the costs of making policy changes both in terms of money outlays and in terms of interruption, confusion, and restructuring of operations (Weiss, 1995). They also have to consider feasibility - who will approve the changes, who will oppose and what kinds of flak might fall upon their heads. They have to worry about whether qualified staff will be available to implement the changes, such as new modes of health services, and whether facilities, such as clinics, can sustain them.

Walt (1994) sees Easton's (1965) political systems model as a useful conceptual tool for comprehending the workings of political systems. It incorporates the idea that *inputs* - demands, support, resources - are directed towards and absorbed by government institutions, resulting in *outputs* of goods and services. However, this essentially linear model does not adequately reflect the inherent complexity of political systems. It does not

pay enough attention to the issue of *what* mechanisms are available for the expression of demands, nor does it adequately account for:

> conflict and the imperfect balance of power and influence, of *who* benefits from the state's outputs. It assumes that the state is neutral in its handling of demands, balancing the different values according to availability rather than according to the relative power of those making the demands. (Walt, 1994, p. 16)

The State's Role in Policy

The policy process is always impinged upon by exogenous factors, which include situational, structural, cultural, and external or international factors (Walt, 1994). Some situational factors are related to crises, such as wars and major change in political leadership and ideology. Structural factors include change in the political regime, technological change, a change of direction in the macroeconomic policy [e.g., in South Africa the Growth, Employment and Redistribution Macroeconomic Strategy (GEAR)]. Walt notes that in terms of health policy, the health services developed in a country are intrinsically linked to the economy of that country. Social and demographic factors, such as birth rate and the transmission of HIV/AIDS and other STDs also affect the policy process.

Trade agreements, bi- or multi-lateral aid, multi-lateral financial institutions are examples of external or international factors which can directly impact on a state's decisions in regards to policy (Walt, 1994). The complexity of the state often contributes to an unwieldy policy-making process: policies become unpredictable and difficult to co-ordinate which, in turn, leads to huge impediments for coordinating intended policy impact (Czerniewicz, 1998). The capacity of the state cannot be assumed, and a limited

state capacity must be a major consideration in any policy formulation (Leonard & Thomas, 1998).

Friedman (1999) suggests that the state is not a unitary structure but a set of different institutions with different objectives and practices. Thus, the state should be seen as erratic and disconnected. In spite of this, the state may be able to "play a major role in social transformation through legislation and other interventions which 'create space' for change" (1999, p. 13).

Connell (1990, cited in Chisholm & Napo, 1997) sees the state as the central institution of gendered power, and part of a wider structure of gender relations that embody violence or other means of control. Chisholm and Napo (1997, p. 4) argue that the state is more significant in influencing gender inequalities than the market and its contradictions create "windows of opportunity for transformative possibilities and organised action". They point out that feminists have in recent years also placed greater emphasis on intervention in and through state policy to effect social change in gender relations. Meer (1999) comments that in post-apartheid South Africa women activists look to the state as a vehicle for realising feminist aims and objectives. She says that the problem is that the state's reliance on legal mechanisms/rights claims in effect hinders transformation of the status quo by, amongst other things, creating the impression that power relations have been resolved. According to Unterhalter (1999) feminists are divided as to whether the state is or is not a vehicle for gender justice, with some arguing on the need to work outside of the state. Feminists are grappling with the dilemma that

> [T]he state can be coercive and deeply implicated in discriminatory gender regimes, but that without state power in curriculum reform...gender justice cannot be fully effected. (Unterhalter, 1999, p. 29)

The Policy-Making Process

The policy-making process or policy cycle is made up of many different dynamic and interdependent levels (e.g., ideology formation, agenda setting, policy design/adoption, implementation, evaluation), which in various combinations or separately constitute a particular level(s) of political judgment (Hoppe, 1993). Lynn's 1981 model focuses on the "high, middle, and low games" of the policy cycle (cited in Hoppe, 1993, p. 82). The "high game" consists of interaction between ideology formation and agenda setting, and is dominated by political party elites, political think tanks, prestigious political commentators and ideologues, and others of similar ilk.

They debate issues on the levels of *rational choice*[1] and *systemic vindication*[2]. The "middle game" consists of interaction between policy design/adoption and the initial stages of implementation (Hoppe, 1993). Its players are the legislature, the upper and middle levels of the executive branch, interest groups, lobbies, journalists, and spokespersons of various social and political movements. Debate focuses on the borderlines and interdependencies between *systemic vindication* and *situational validation*[3].

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[1] At the level of *rational choice*, dominant societal value systems and the social order are compared with alternatives.

[2] At the level of *systemic validation*, policymakers' value systems are examined to determine their contribution to the dominant social order.

[3] At the level of *situational validation*, the arguments address the appropriateness of program goals, in view of both the decision makers' broader value orientations and their perception of opportunities and constraints in the decision-making situation.

The "low game" is a continuous interaction between policy implementation and evaluation processes that results in the termination, adjustment, or maintenance of programmes. This arena is made up of middle- and lower-level members of the executive branch, as well as the courts because they "arbitrate the many controversies over concrete policy decisions and actions brought to court" (1993, p. 82) by diverse members of the public. Their debates focus on the interface between *technical verification*[4] and *situational validation*.

The major problem for Hoppe (1993, p. 84) in the above is that the policy process fails to unite different sets of policy actors because

> Specialists concocting policies at the levels of rational social choice and systemic vindication are no longer 'on speaking terms' with or 'within earshot' of the experts who implement, evaluate, and experience programs at the situational validation and technical verification levels.

What this means in practice is that the policy cycle becomes a problem to itself and therefore "no longer enables other problems to be attacked" and it can "no longer preserve or improve the capacity to make better policy decisions" (Hoppe, 1993, p. 84) in the future. Hoppe suggests that, given policy analysts prominent position in many policy-making processes, they can (and should) take practical steps to change this situation, firstly, by ascertaining an argument's political plausibility for the target audience. Secondly, to do this within the policy-making process in such a way that it maintains and enhances the political community's character of authentic debate and collective action.

[4] At the level of *technical verification*, the arguments concern questions about meeting goals and using resources efficiently.

Central to Walt's (1994) conceptualisation of the policy-making process is the ways in which power impacts on the process. Friedman (1999, p. 8) makes a similar point; for her "every step of the policy-making process is about politics and power." Walt looks at power through the lens of two dominant views: the pluralist view, and the elitist view. The classical pluralist view sees power as diffused throughout society. In other words, the perception is that no one group holds power over other groups. Observations of the workings of liberal democracies underpin this view, where governments are seen to be unbiased arbiters between many competing interests. There are many that challenge the perception that the state (or government) is a neutral negotiator between different interests, however, especially in that governments do have

> substantial power which is strongly linked to the interests of other powerful institutions such as the military, sources of capital, boards of banks [who] only promote policies that serve their own interests. (Walt, 1994, p. 36)

An elitist view of the policy-making process is often underpinned by Marxist theorisation (Walt, 1994). Policy choice or policy reform is seen as dominated by one particular social class and, within this context, the state's primary function is to reinforce the status quo. Walt argues that elitists reject pluralist views on policy for three main reasons. Firstly, they claim that access to the political elite - the only group able to influence policy - is open to the dominant economic classes exclusively. Secondly, interest groups are not equally powerful especially in commanding different levels of resources. Thirdly, powerful forces of economic domination that lie outside of state activity are ignored by pluralist conceptualisation. These forces include transnational companies and international multi-lateral organisations, such as the World Bank and the International Monetary Fund (IMF).

Nevertheless, Walt (1994, p. 39) suggests that, within the policy development context, "the elitist view overstates the capacity of elites to wield power". She points to the fact that so-called non-elites do challenge elites; and that the vastly wide-ranging nature of government policies preclude any one group or social class from dominating over all policy issues. She further takes a cue from Hall et al (1975) who suggest the notion of "bounded pluralism" where, on the one hand, issues of high politics - mainly economic - are decided within an elitist framework. Most health policies, however, are likely to be developed along pluralist lines. Underlying this is the perception that "with non-controversial issues there is room for manoeuvre in the policy process" (1994: 39) because of a government's greater flexibility and openness to diverse sources which are perceived by government policy-makers as legitimate.

Czerniewicz (1998) suggests that a more fluid perception of policy-making is becoming part of mainstream thinking, where the view of policy as uncomplicated and stagist is being strongly countered by one which sees policy as dynamic, convoluted and interactive. Basically, policy-making is a balancing act of diverse interests or tensions represented by actors - individuals, groups or institutions - who come to some sort of compromise within relations of power:

> Understanding policy-making implies understanding who the actors are..., which actors are active, which are passive, which are present and which left out. (Czerniewicz, 1998, p. 33)

A common perception is that policy-making entails a series of decisions made by an identifiable person or set of "decision-makers", but in practice decision makers do not

feel at all empowered to make decisions (Trostle, Bronfman & Langer, 1999). Studies show that their work processes are filled with compromise and referral more often than rational choice based on evidence. The framing of a policy issue always takes place within a nested context (Rein & Schon, 1993). In practice, this means that policy issues usually arise in connection with governmental programmes that exist within a particular policy environment, which is part of some broader political and economic setting, which is located, in turn, within a historical era.

In similar vein, but advancing the argument to include the role of actors and power, Walt and Gilson (1994) see policy-making as a dynamic process where decisions over policy content reflect what is politically feasible at the time of policy choice within a specific framework or context. The behaviour of actors in formulating and implementing policy is a central aspect of this process. Actors influence the values that become inherent to policy as well as which policies are chosen for development. Just as important is the power structure within which the policy process is developed, especially given that "policy reforms often depend on political compromise and not on rational debate" (1994, p. 366).

Friedman (1999) says that the policy process does not end with the passing of legislation; acts go to the public and to the implementers who are often not the original policy-makers. She suggests that in practice, policy-making seldom proceed in an *orderly* manner. For example, there may be little coordination of overlapping processes. Communication gaps between policy writers and budget allocators are common, and this means a disjuncture between policy objectives and allocated resources. Implementers of

new policy may be fairly "clueless" about what they are meant to do. A critical consequence here is that poor implementation can vitiate good policy. An example of the latter is cited by Pandy (1999) who suggests that, despite progressive policies in place, little progress has been made in reducing illiteracy rates among South African women. She argues that this is partly due to disparities between policy and implementation.

Friedman (1999) also raises the critical point about a disjuncture between the discourse of policy and that of a law. She comments that "it is often at the point where policy is translated into law that gender equality gets dropped" and that this may partly be due to law-makers not "always know[ing] how to conceptualise the policy requirement" (1999, p. 14). An audit commissioned by the Commission on Gender Equality in 1999 similarly suggests that much of the inequality and discrimination that women experience occurs in the application of the law (Maharaj, 1999). It seems that a so-called neutral law can have an adverse effect on women, or a good law can be poorly implemented and administered.

WHAT IS POLICY ANALYSIS?

Policy analysis emerged in the late 1960s, mainly in the United States. During this time, policy research became a growth industry for think tanks, university research institutes, and management consultant firms, which, in turn, promoted the development of the discipline of policy analysis (Fischer, 1993). Policy analysis draws on a number of disciplines, such as economics, political science, sociology, public administration and history. Conceptualisations of policy analysis amongst scholars are markedly varied, fostering a confusing array of different theories ranging from the highly prescriptive to the more descriptive (Walt & Gilson, 1994).

Policy analysis often focusses on the approaches, methods, methodologies and techniques for improving discrete policy decisions (Walt and Gilson, 1994). Policy analysis also may be concerned with the task of analyzing and evaluating public policy options in the context of given goals for choice by policy-makers or other relevant actors. For Walt and Gilson a central problem with these approaches is that they are similar to those characterized by the incrementalist or rational schools of policy making. For instance, these approaches imply that:

> [P]olicy-makers are concerned largely with the content of policy, are intendedly rational, and need to have particularly skills to make proper choices among well-defined alternatives in the furtherance of complex but compatible goals. (Walt & Gilson, 1994, p. 358)

Policy analysis is seen as a form of intellectual activity that may function as cause or consequence of movements within the processes of a larger policy discourse[5] (Rein & Schon, 1993). Hoppe (1993, p. 79) notes that, given policy analysts constant concern with political judgement, it would be safe to characterize policy analysis as "the production of political judgments". Leonard and Thomas (1998) view policy analysis as being a structured way of thinking about choices before deciding on a particular course of action. An important aspect of the process is to grasp and to be sensitive to the context in which the problem is presented. Perceptions of and interpretations of problems and solutions will vary, often substantially, amongst the key stakeholders involved in the process. Quinn (1996) argues that a thorough policy analysis provides information on the intent of a policy, as well as on the results of its implementation.

[5] *Policy discourse* refers to the interactions of individuals, interest groups, social movements, and institution through which problematic situations are converted to policy problems, agendas are set, decisions are made, and actions are taken.

Policy analysis and policy advocacy necessarily is linked but essentially divergent processes (Leonard & Thomas, 1998). In brief, policy analysis explores possible implications or outcomes of adopting a particular policy. Policy advocacy is concerned with how best to persuade others that the policy you want is the best for everyone else to adopt. The positive implications of policy analysis for Leonard and Thomas include, firstly, that it provides a useful set of tools for choosing the best course of action among various alternatives. Secondly, policy analysis helps policy-makers identify reasons for choosing a particular course of action. This, in turn, enables policy-makers to promote and defend policy choices. Lastly, policy analysis helps towards deciding whether to support the policy proposals of other parties. Leonard and Thomas suggest that these implications may be particularly useful within a context of many new policies being designed to overcome the unforeseen shortcomings of previous policies.

Health Policy

The following section of this thesis briefly reviews Walt's (1994) and Walt and Gilson's (1994) approach to analysis of health policy. The researcher believes that, in terms of the aims of this study, their approach to policy analysis is both relevant and important. For instance, they point out that health policy encompasses courses of action that affect all aspects of the health care system, but also includes actions by other actors that have an impact on health. Moreover, their approach is centrally concerned with the role of *process* and *power* in the policy-making process. This concern constitutes a significant shift away both from mainstream health policy analyses and the broader policy analysis arena. The issues of process and power in the policy-makinf process are also a major concern for this researcher.

Walt (1994) talks about the ways in which political systems, power and influence and the participation of people impact on the policy-making process. She borrows theories from different disciplines in the social sciences and then "uses them eclectically" in order to

> give readers a flavour of the different arguments derived from different theories, and to create an over-arching framework for analysis that takes the kernel from each theory and uses it to develop a way of understanding the complex world of health policy (Walt, 1994, p. 3)

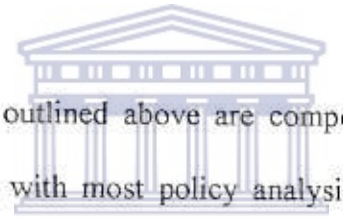
The aim is to create a broader framework, which (1) takes account of the basic structural concerns of the society-centred approaches about where power lies, and (2) overcomes the weakness of the state-centred approaches which concentrate too closely on government control of the policy process. This much broader framework for thinking about health policy would then be characterised as one in which policy is conceptualised as the outcome of complex social, political and economic interactions (Walt & Gilson, 1994). This approach is centrally concerned with processes of policy-making, but is just as concerned with the behaviours of actors in formulating and implementing policy and the context within which policies are made.

Walt (1994: 42) differentiates between policies by dividing them into "high politics" (systemic or macro policies) and "low politics" (sectoral or micro policies). High politics is defined as the maintenance of core values - including self-preservation - and the long-term objectives of the state. Low politics are issues perceived as neither involving fundamental or key questions relating to a state's national's interests, nor those of important and significant groups within the state. Reform of the health sector may be treated as high politics, especially in a crisis environment. However, health policies more often fall into the category of low politics.

According to Walt and Gilson (1994), arguments against policy analysis include that:

- All policy is decided for political reasons, and is therefore unique in time and place
- Policy analysis is immensely complex and the social sciences cannot hope to be precise about outcomes
- Access to information is difficult and often delicate
- Within unstable political situations, policy analysis may become quickly outdated
- Given that it is based on Western concepts, policy analysis is not applicable to less developed countries

Countering these perceptions, Walt and Gilson (1994) argue that a central reason for policy analysis is precisely to influence policy outcomes.



The frameworks of policy analysis outlined above are compelling and useful for this research. However, and in common with most policy analysis frameworks or models, they fail to specifically direct a gendered approach to the policy process. This means that there is no investigation of the immediate and long-term effects of policy on women's (or men's lives). It is an approach that reflects a lack of considering problems and solutions based on people's diverse experiences in different contexts. Moreover, the gender-neutral language used in much policy may obscure the differential effects of policies. Language used is often intentionally broad and ambiguous, and thus the outcomes of implementing the policy may be different from what was intended (Quinn, 1996).

Theoretical frameworks that attempt to rectify the lack of attention to gender in policy analysis are outlined below. These approaches are critical for this research and are drawn on in the course of this study.

GENDERED FRAMEWORKS FOR POLICY ANALYSIS

> [The South African state] has committed itself to ensuring that a gender perspective is central to all policies and programmes. To this end, there is an impressive array of formalised 'gender structures' and national machinery whose effectiveness requires further analysis. (Friedman, 1999, p. 4)

De le Rey and Kottler (1999) argue that, although uneven across sectors, three approaches to gender are evident within policy documents and debates (de le Rey & Eagle, 1997, cited in de le Rey & Kottler, 1999). There is the *gender-blind* approach where gender is completely ignored as a source of discrimination. In essence, this approach is one of omission in that issues are dealt with as if there is no differential affect due to gender. The second approach is the *add-on* approach. It is characterised by treating women as a separate add-on sector together with other groups such as young, disabled and rural people. Whitcutt's (1999, p. 81) pointed comment on this approach is that gender needs to be considered in its own right and not reduced to the entirely inadequate vehicle of "women-and-youth-and-other-special-interest-groups". Further, Zwart (1992) argues that the struggle for women's emancipation is much more than using the right terminology, or adding a woman to a project or programme.

In the third approach - the *women and children* approach - women are identified only in terms of their roles as mothers within families. The latter two approaches are politically problematic in that they fail to

> adopt an integrative approach to gender [and this] runs the risk of glorifying the role of women in their separate sphere. Implicit within such approaches is a type of conservatism that may simply reinforce a view of reality that is split into separate domains of life for women and men. (de le Rey & Kottler, 1999, p. 121)

According to Olckers (2000), monitoring of legislation should focus on whether Acts address women's practical needs; i.e., whether the legislation is going to help women in their reproductive, productive, and community management roles. Looking at some areas where this "help" is less than adequate, she cites policy that deals with education and training. For example, the education system is characterised by inadequately trained educators, racism in some schools, gender stereotyping in curriculum and in career advice. These practical obstacles will also impact on implementation of the Skills Development Act, especially in the areas of curriculum and career advice. Similarly, although specific health policy and legislation has been reviewed or formulated to benefit women[6], important practical obstacles for effective implementation include a lack of adequate public education, and inadequate pre- and post-counselling services for termination of pregnancy.

Friedman (1999, p. 9) argues that in the policy process identifying a problem and the process by which a "problem" is defined and evolves into an issue requiring research is entirely political. Unspoken questions around identifying a problem include: (1) Who decides that this is a problem? (2) How are the different experiences and perceptions of the problem defined, understood and interpreted? (3) Whose voices are listened to? Further, knowing the distribution of women and men in the policy-making process has important implications for gender equity. In this regard, it is useful to know, firstly: Which women and which men are involved in the development of policy proposals.

[6] Olckers (1999) is referring to: the Choice on Termination of Pregnancy Act (No. 92 of 1996); Notification of Maternal Mortality (1997); free pre-screening for cervical cancer for women over 40 years old; the Sterilisation Act (No. 44 of 1998) which, for anyone over 18 years old, does not require a partner's consent; and the Health Promoting Schools Policy Guidelines.

Secondly, what their skills and political commitments are. These are important issues because:

> [T]he way problems are defined in terms of gender has significant implications in determining the forms of intervention and assumed beneficiaries. In other words, which women's material life conditions will actually be addressed and potentially improved, is heavily shaped by the way the problem is named. (Friedman, 1999, pp. 11-12)

In her conceptualisation of the policy process, Friedman (1999) raises the central issue of how to develop policy in ways that do not lead to the normalisation and standardisation of reality which, she argues, is a central problem for all policy-making. The dilemma for Friedman seems, more or less, to be: Is it possible to accommodate the fluid nature of people's lives, their multiple identities and realities within policy frameworks which by definition largely function to circumscribe people's identities and flatten the complexities of difference?

Barbara Klugman (1999) has developed a conceptual framework to analyse health policy, directly drawing on Walt and Gilson's (1994) approach to the policy-making process. The framework is structured around what she perceives as the most important factors impacting on policy development, which are:

- Context
- Problem identification and solution development
- Actors
- Political process
- Content defined in policy and through implementation

Recognition of policy as resulting from diverse and diffuse influences, Klugman (1999) argues, requires policy analysis to be an interrogation of political, economic, social,

cultural and historical contexts. A central purpose of Klugman's analytical framework, however, is to account for gender impact within the policy-making process. It is in this respect in particular that makes Klugman's approach very useful for this study.

Two important motivating factors for Klugman (1999) in developing this analytical framework are, firstly, that gender equality is central to the international health agenda. Secondly, in South Africa gender equality is an end in itself, reflected in the Constitution. The South African Bill of Rights specifies which rights enable the exercise of equality, such as the right "to make decisions concerning reproduction"; the right to "bodily and psychological integrity"; and the right "to security in and control over one's body" (Section 12). Other provisions in the Bill of Rights which impact on equality in health and social development include access to health care, safe environment (not hazardous to health), food, nutrition, and social security which includes appropriate social assistance (Sections 24 and 27). This attention to gender equality reflects evidence that

> [F]ailure to address gender equality undermines the capacity of health services to function effectively, to meet the needs of their employees, and to meet the needs of clients, irrespective of gender (Klugman, 1999, p. 49).

Moreover, failure to address gender equality undermines women's ability to exercise other rights; for example, the right to health care. Central to addressing gender equality is gaining an awareness of the impact of discrimination and inequality, including gender inequality, on the health of men, women, adolescents and on health services (Klugman, 1999). Klugman additionally argues that there needs to be a willingness to change the policy process to ensure that health services contribute as much as possible both to good health and social transformation. This will entail going beyond a focus on poor women as

targets of public health services; increasing the numbers of health centres, the range of services provided and the technical skills of providers.

In similar vein, but specifically addressing mental health policy, de le Rey and Eagle (1997, p. 148) argue that it is essential that policy be designed "to tackle structural and ideological barriers, social and personal constructs, patient/client and healer attitudes and the inter-relationships between them". They make the central point that addressing gender concerns in policy formulation involves challenging unequal power relations and their implications. Meer's (1999) study on gender equity and land reform in Elandskloof in the Western Cape is a case in point. She comments that women are less likely to make gains in situations where the allocation of contested scarce resources depend on existing unequal power relations between men and women.

The present thesis is also informed by the work of Hilary Standing (1997). Standing reviews the literature on gender and equity in health sector reform programmes in developing countries. She notes that, compared to concern about the implications of reform on the poorest sections of populations, little attention is paid to gender which is also an "important dimension of vulnerability" (1997: 1). Further, the possible impact on the gender composition of the workforce is not considered in proposals and strategies to restructure health service employment. These issues can be better understood by considering two approaches to women's health found in the literature: (1) the women's health needs approach, and (2) the gender inequality approach.

The women's health needs approach is concerned with the implications for women of differences in the epidemiological profile between the sexes. It highlights the specific health needs of women and girls as a consequence particularly (although not exclusively) of the biology of reproduction. Two broad stances derive from this approach (Standing, 1997, p. 2):

1. The need to provide specific, women focused health care interventions as a basic right in order to address the imbalance of need; and
2. The cost effectiveness of interventions which target women and girls, both in comparison to other types of interventions and as a means to improve the health of infants in particular.

The gender inequality approach is concerned with the role of gender relations in the production of vulnerability to ill health, and particularly the conditions which promote inequality between the sexes in relation to access and utilisation of services (Standing, 1997). Thus, it is centrally concerned with power relations and the ways in which health may be a site of gender conflict.

A gendered approach to policy analysis also requires a look at the way society locates women and men in relation to all areas of their lives, such as the workplace, the domestic sphere (the 'public-private' divide) and the civic life of the community (Goldblatt & Meintjes, 1996). Gender differences are constructed in relation to particular historical, cultural, political, and economic contexts and are in a constant process of contestation and change (Clark, 1997). They are not uniform but intersect with other key factors of individual and group identity such as age, race, class, region, religion, sexual orientation and ethnic identity. All of us live as gendered beings.

This chapter has examined the literature on the policy-making process, explored the nature of policy and policy analysis, and identified policy analysis frameworks particularly relevant for this research. In doing so, the importance of a gendered approach to policy analysis has emerged as critical for gender equity in the policy arena. The next chapter of this thesis (Chapter 3) provides a discussion of the methodological approach used to analyse the Mental Health Care Bill, 2000 and the Skills Development Act, 1998.

CHAPTER THREE
METHODOLOGY

This methodology chapter provides an explanation of the methodological approach used to conduct this study. The approach entailed an analysis of the Mental Health Care Bill, 2000 and the Skills Development Act, 1998 that draws on the work of selected writers, secondary data and data collected through a survey of key informants.

METHODOLOGICAL APPROACH

The legislation analysed in this study is the Mental Health Care Bill, 2000 and the Skills Development Act, No. 97 of 1998. The same methodological approach (see below) is used to analyse the Bill and the Act. Both of these government policies are analysed in terms of how they impact on women, particularly poor and marginalised women. Within a range of health and social policy, the Mental Health Care Bill and the Skills Development Act exemplify types or categories that appropriately accommodate a gendered approach to policy analysis. In this way, the links between the two should emerge. The reason for selecting the Bill and the Act is that the former represents a generic health policy (a framework for mental health policy), and the latter represents an intersectoral social policy.

In order to address the questions raised by the aims for this research[1], the researcher analyses the Bill and the Act separately primarily drawing on the gendered theorisation of

[1] As outlined in Chapter 1, "Aims of Study".

Klugman (1999), Friedman (1999), de le Rey and Kottler, 1999 and de le Rey and Eagle (1997). This means use of a methodological approach to policy analysis that argues for impact of context, actors (i.e., "policy activists"), problem identification, solution development, political process, content defined in policy and through implementation, power and, crucially, gender.

Use of Secondary Data

To facilitate and substantiate the above process, secondary sources or data are also used. Beyond reading and analysing the policy, the researcher sought as much written data as possible on it, including reports, media and other articles, submissions to Parliament[2], and minutes of Portfolio Committee meetings, and other relevant documents. The researcher made a special effort to access written material from organisations such as the Women's Health Project (WHP), Gender Advocacy Project (GAP), and the Women and Rights Project, Community Law Centre, University of the Western Cape. These organisations monitor policy, make submissions to Parliament on proposed legislation, and generally provide an important role as advocates for gender to be an integral element in all government policy. Other non-government organisations such as the National Progressive Primary Health Care Network, Health Systems Trust and Child Health Policy Unit, University of Cape Town have also been very useful resources. The researcher also accessed government and parliament websites and documents for information on the legislation.

[2] The researcher was not able to access any of the submissions to the Department of Mental Health.

Survey of Key Informants

An important tool for collecting data for this research was a survey of key informants involved in the policy-making process. The aim of the survey was to gain an understanding of the ways in which stakeholders understand issues of gender in the policy process. Selection of key informants and methodological approach was discussed at a meeting between the researcher and supervisors. Based on this discussion, the researcher emailed open-ended questionnaires (Appendix A) to selected informants who were in a position to answer questions in regards to mental health or skills development policy and gender. Questionnaires were emailed to:

- Two informants at provincial government mental health programmes
- One informant at the mental health directorate (Department of Health)
- Four informants at Employment and Skills Development Services (Department of Labour)
- One informant at the National Skills Authority
- Three informants from industry (Old Mutual, Liberty Life, A. Levy)
- Three informants at National Education & Health Allied Workers Union (NEHAWU)
- One informant at Congress of South African Trade Unions (COSATU)
- One informant at National Congress of Trade Unions (NACTU)
- One informant at Psychological Society of South Africa (PSYSSA)
- One informant at the Commission for Gender Equality (CGE)
- Six informants based at NGOs (i.e., Centre for the Study of Violence and Reconciliation, Gender Advocacy Programme, Cape Mental Health Society, Women and Rights Project, Centre for Health Policy)

A total of twenty-four questionnaires were sent to key informants. The researcher received ten written responses to the questionnaire, eight of which were by email. All the selected sectors were represented by the responses, except for the trade unions and the counselling professionals.

Key informants were emailed the questionnaire (in one case the questionnaire was faxed because the respondent's email was not functioning). There was one set of questions for government officials, and one set for NGOs, trade unions, and industry. The questions for government officials were specifically aimed at gaining an understanding of how gender is dealt with in developing, implementing and monitoring policy. In this respect, it was important to include two questions about consultation during the policy process (i.e., with the CGE and gender NGOs). The questions for NGOs, trade unions and industry were more concerned with issues of effective participation in the policy-making process specifically in respect to gender issues (e.g., submissions, differential impact due to gender, monitoring of implementation). A covering letter that outlined the purpose of the study was sent with the questionnaire (Appendix A). Respondents were informed that responses would be strictly confidential. Respondents were given the option to respond to the questionnaire by telephone, fax or e-mail.

The next chapter of this study (Chapter 4) provides a gendered policy analysis of the Mental Health Care Bill, 2000 and the Skills Development Act, 1998. The analysis is informed by the theoretical conceptualisations on the policy-making process and on policy analysis frameworks discussed in Chapter 2. It is specifically underpinned by the gendered conceptualisations of the policy-making process and policy analysis frameworks. The responses of informants who replied to the survey questionnaire described above are intertwined with, and form an important component of the analysis of the Bill and the Act.

CHAPTER FOUR
ANALYSIS

This chapter provides a gendered policy analysis of the Mental Health Care Bill, 2000 and the Skills Development Act, 1998. The analysis is informed by the researcher's careful reading of the Bill and the Act, data obtained from the questionnaires sent to key informants, and by secondary sources (described in Chapter 3). The analysis is underpinned by the gendered theoretical perceptions of the policy-making process and the gendered policy analysis frameworks discussed in chapters 2 and 4.

Throughout the analysis process, the researcher is acutely aware that there is no monolithic or universal category "woman" or even "poor and marginalised woman". Policy and its implementation impacts on women in diverse ways depending on their particular positioning within social relations. As Chandra Mohanty (1991a, p. 55) writes, women are not "an already constituted, coherent group with identical interests and desires, regardless of class, ethnic or racial location, or contradictions". Critical feminist Mbilinyi (1993) argues that identities as women (and men) are unstable, inconsistent, ambivalent, and contradictory. She insists that identities are not given or reducible to our origins, skin colour, or material locations. Rather, identities or positions are the product of struggle and they represent an achieved, not an ascribed trait. Moreover, as Mbilinyi points out, women are not passive victims. Strategies of accommodation, resistance and struggle have changed according to time and place, and vary for different kinds of women.

GENDERED POLICY ANALYSIS

This section of the thesis provides detailed summaries of the Mental Health Care Bill, 2000 and the Skills Development Act, 1998 followed by a gendered policy analysis of both the Bill and the Act. The analyses of the Bill and the Act are framed by data collected from the questionnaires sent to key informants. The gendered policy analyses of the Bill and the Act are underpinned by the theoretical postulations that are discussed throughout this thesis.

Summary of the Mental Health Care Bill, 2000

Mental health issues are part of the broader agenda for transformation of the health sector. The Mental Health Care Bill, 2000 moves towards a health rights approach to mental health care. This implies a shift towards mental health policy that is based on non-racial, equitable, local-community orientated principles. The shift reflects a dramatic change from the hospital-based custodial or preventive model of care sanctioned by the Mental Health Act (No. 18 of 1973). The Bill constitutes a re-write of the 1973 Mental Health Act.

The main objectives set out in the Bill are, firstly, to provide the best mental health care, treatment and rehabilitation within a context of available resources. Secondly, to enable equitable access and availability for all to efficient mental health care services - in the best interests of the mental health care user. Thirdly, to integrate mental health care services into general health care. In addition, the Bill states that the government must implement the new policy in a manner that ensures:

- Provision for mental health care, treatment and rehabilitation services at primary, secondary and tertiary levels and at specialised health establishments[1]
- Promotes community-based care, treatment and rehabilitation
- Promotes and advances the mental health status of the population
- Ensures appropriate care, treatment and rehabilitation is provided to any person requiring it, i.e., everyone has a right to access to mental health care services

The provisions in Chapter 3 of the Bill (The Rights and Duties Relating to Mental Health) are consistent with provisions in the Bill of Rights in the Constitution. For instance, the provisions include that every mental health care user is entitled to respect for their person, human dignity and privacy. Further, according to the Bill no person is to be subjected to care or treatment, nor be admitted to a health establishment for such care or treatment unless s/he gives consent. Mental health care users may not be unfairly discriminated against on the grounds of their mental health status, and must receive treatment in accordance to standards equal to other health care users. Policies and programmes must be implemented in such a manner that enhances the mental health status of users.

In addition, mental health care providers must ensure that users are protected from exploitation, physical or other abuse, neglect and degrading treatment. The Bill provides that determination of a person's mental health status may not be based on socio-political or economic status nor on cultural and religious background or affinity. It further states

[1] "Health establishment" means institutions, facilities, buildings or places where persons receive care, treatment, rehabilitative assistance, diagnostic or therapeutic interventions or other health services and includes facilities such as clinics, mobile clinics, community health and rehabilitation centres, hospitals and psychiatric hospitals.

that no person or health establishment may disclose any information which a mental health care user is entitled to have kept confidential. According to the Bill, a user is entitled to assistance from a legal representative in respect of any provisions set out in the Bill. On discharge from a health establishment, the user must be issued with a discharge report. The Bill also states that all users of mental health care services must be informed of their rights *prior* to care or treatment.

Chapter 4 of the Bill provides for the establishment of provincial Mental Health Review Boards. Each Review Board is to consist of up to five people, one of which must be a mental health care practitioner and another an attorney or advocate. The functions of the Review Boards are to: (1) review all applications for assisted and involuntary admissions; (2) receive reports and make decisions in relation to such admissions (which are forwarded to the high court); and (3) listen to all appeals for and against such admissions. This constitutes a shift in emphasis from a legal perspective to one that is based on clinical judgement and skill. The final responsibility for admission orders will continue to rest with the legal/justice system, but the process leading up to these decisions will be based on a clinical point of view. For users of mental health care services, a Review Board will serve to provide a buffer between clinical service providers and the justice system.

In the Bill, the term *medical practitioner* has been replaced with the term *mental health care practitioner*. This change in terminology signals a move away from a dominant medical model of mental health care, and it has important implications with regard to

assisted and involuntary admissions, and for mental health care services generally (Subedar, 1999). A *mental health care practitioner* is defined as a psychiatrist, clinical psychologist or registered medical practitioner, nurse or social worker (with specialised training).

Chapter 5 of the Bill deals specifically with the provisions that govern admissions categorised as Voluntary, Assisted and Involuntary admissions. Chapter 6 provides for State Patients, and Chapter 7 deals with Prisoners Who Are Mentally Ill.

Voluntary admissions refer to mental health care users who voluntarily present themselves at a health establishment for care, treatment and rehabilitative services. An *assisted admission* to a health establishment takes place when a mental health care user is considered incapable of making an informed decision on the need for mental health care services. In this instance, a written application is required from the user's spouse, next of kin, partner or associate, parent or guardian, or a mental health care practitioner. *Involuntary admissions* take place when a user does not give consent to be admitted to a health establishment, but is nevertheless considered incapable of making an informed decision on the need for care and treatment, or is unwilling to receive the care or treatment required. Again, a written application submitted by any of the above mentioned persons is required to admit to a health establishment a person who has not given his/her consent for admission and treatment. As mentioned in the section on Mental Health Review Boards, decisions regarding assisted admissions and involuntary admissions will be based substantially on the recommendations of a Review Board.

The draft Mental Health Care Bill, 2000 was published for comment in the Government Gazette on 4 February 2000. The Department of Health aims to submit the Bill to Cabinet in early August. The Minister of Health hopes to table the Bill in Parliament by the end of this year.

Gendered Policy Analysis of the Mental Health Care Bill, 2000

The transformative, rights approach embodied in the Mental Health Care Bill is highly commendable, and long overdue. Especially critical in this respect are the provisions in the Bill that deal with restoring and protecting the respect, human dignity, privacy confidentiality, and consent to care and admission of mental health care users; and the attempts to destigmatize mental health by prohibiting discrimination on the basis of mental health status. It is important that the Bill provides that mental health care users must be informed of their rights before they are given care or treatment.

The legislation should help to foster a more sensitive and caring environment for mental health care users, who are vulnerable to unfair discrimination due to the stigma attached to their health status. The Bill aims to provide appropriate and effective mental health care, and to increase access and availability to mental health services. It also aims to integrate mental health care services into general health care. These provisions are particularly important for the many South Africans who struggle to access available and good quality mental health services. The Mental Health Review Boards are also important as a mechanism towards restoring rights and creating a possible vehicle for more public participation around issues of mental health.

Gender-Blind Approach: "All equally vulnerable"

Notwithstanding the far-reaching aspects of the Bill, it appears that government hopes to meet its objectives without serious consideration to gender issues. De la Rey and Kottler (1999) discuss three approaches to gender evident within policy debates. The *gender-blind* approach is one such approach. It is described as ignoring gender as a source of discrimination "in that issues are dealt with as if there is no differential affect due to gender" (p. 121). Responses from informants within mental health programmes from provincial and national departments of health seem to corroborate this gender-blind approach. For example, one respondent said

> All mental health care users are disadvantaged or stigmatized due to their mental health status, thus all are equally vulnerable.

Another respondent comments that

> [G]iven the intention and scope of the Bill, specifically its focus on broad human rights, the lack of specific *reference* to gender is probably appropriate. (Emphasis in the original.)

Similarly, another respondent points out that

> Given past infringement of the rights of men and women with mental disabilities the main focus of the bill was to promote these rights for all.

The Bill attempts to redress this discrimination by promoting and protecting the rights of all mental health care users. The implication is that a focus on gender is unnecessary, if not irrelevant. Yet, an undifferentiated or "neutral" view of the mental health experiences of men and women dangerously promotes or perpetuates a policy framework that does not challenge gender relations of power.

Community-Based Care: Where Does this Leave Women

The Bill promotes the provision of community-based care, treatment and rehabilitation in communities. This raises a number of important questions. For instance, what will this mean in practice? In particular, how will this impact on women and on scarce resources? Although unspoken, there are strong indications that in practice "community-based care" means that the primary caregivers will be women[2]. How will poor and under-resourced communities, and especially women in these communities, deal with the added burden of care? How will government fulfill its obligations and responsibilities towards providing and sustaining the necessary social assistance, support, education, and flow of information to women? A concerted effort in this respect is required for rural women. This is a particular concern in that a number of provinces have identified mental health as a provincial strategic priority over the next five years; for example in the Eastern Cape, Northern Province and North-West (personal communication).

The Department of Health needs to undertake a thorough and comprehensive investigation on the implications of this strategy for communities, and especially for women in the communities. Monitoring mechanisms need to be put in place in order to monitor the impact of the legislation on women, as well as to ensure that the Bill is successful in promoting mental health not only for users but also for caretakers. In this regard, a respondent from the department of health makes the following comments:

[2] See Chapter 5 for a more detailed critique of this perspective.

> Cognisance was also taken of the fact that community care may well put added pressure on women as (primary) care givers. However this cannot override the right of mentally ill (men and women) to be part of their community and live as 'normal' a life as possible. We believe that it is a very serious decision to remove a person involuntarily and this should only be done in exceptional circumstances. In our policy proposals we regularly state that as people are moved into community care settings from hospitals 'the money should follow the patient'. When we get this right there should be sufficient resources in the community to not put unnecessary burden on the women care givers. In fact it could even produce income generating projects for women in poor communities. (Already in certain pilot programmes we have transferred funding to women's organisations to look after deinstitutionalised patients.)

However, a respondent from a NGO suggests that the Bill appears to support a shift from institutionalised care to home-based/community care without providing the necessary infrastructure and resources for these purposes. The main concern for the respondent is that

> This shift in the Bill will impact disproportionately on women, given that they will assume the major care-giving role, and that this impact will occur within a context of existing gender inequalities in society, the caregiving role that women already assume or are imposed with in the context of children, persons living with HIV/AIDS and persons with disabilities. The particular implications of this additional burden must also be viewed in light of its implications for women's economic/financial independence. *It is yet another obstacle to women being able to secure employment and break out a cycle of poverty.* This caregiving role is also likely to carry financial implications, in terms of certain inevitable costs associated with such care. (Emphasis mine.)

Besides commenting on the deficiencies of the Bill in terms of gender equity, the above respondent's comments also highlight links between the Mental Health Care Bill and the Skills Development Act. This is evident in the italicised comment above. The comment suggests that the care-giving role that women are likely to assume will have a direct

impact on whether they will be in a position to access the training and skills development activities set out in the Act, which is meant to benefit both men and women.

Mental Health Review Boards: Advantages and Shortcomings

Establishment of provincial Mental Health Review Boards is important and there can be no doubt that this is consistent with the overall policy direction of the Bill - to protect the rights of users. Can this goal be realised, however, in the absence of clear-cut guidelines in the Bill of the steps to be taken to ensure that key stakeholders are equitably and effectively represented on the proposed Boards? This should include equitable representation of mental health care users on Review Boards. Equity in representation is essential in order to ensure that the credibility of the Boards is not undermined. Two respondents from different NGOs remark on the composition of the Mental Health Review Boards. One respondent says that

> In the composition of the Mental Health Review Board no efforts are made to promote gender equality by stipulating gender representation on the Board.

The other respondent remarks that

> Inadequate attention is given to the issue of gender representivity in terms of structures that are set up. For example, the composition of the Mental Health Review Board makes no reference to the issue of gender or even broader representivity.

This is a crucial area where attention to gender has been neglected, and this important gap in the policy may have dire implications for many women.

Women's Sexuality

Two respondents from departments of health comment on Section 14 of the Bill: "Limitation on Intimate Adult Relationships"[3]. Comparisons are made to provisions in the 1973 Mental Health Act. For instance, the Act prohibits institutionalised women from having sexual relations, referred to as "carnal knowledge". In contrast, according to one respondent, Section 14 of the Bill:

> [C]reates gender equity [and] promotes constitutional rights.

Another comment from a respondent points out that

> [I]n contrast to the present Act (Section 66), intercourse with a female patient should not be treated differently from the situation of a male patient, as we felt that current provision, despite its evident intention of protecting women, is discriminatory. Section 14 of the Bill, while focusing mainly on the question of rights, does take this into account.

These departments of health respondents also pointed out that the clause in the Act prohibiting women from having sexual relations was most likely intended to protect them; and that:

> A lot of discussion was had around this clause (especially as it's the time of HIV/AIDS) and some people felt that the clause in fact opened women up to be exploited, finally though, the right to engage in sexual relations and reproduce prevailed.

On the same issue (Section 14 of the Bill), a respondent from an NGO comments that it is

> [A]n important gender issue.

[3] Section 14 reads: "Subject to the conditions applicable to providing care, treatment and rehabilitation services at a ***health establishment***, the intimate relationships of adult mental health care user's may only be limited, if due to mental illness, the user's ability to consent is diminished."

It is important that the Bill disallows discrimination in terms of sexual relations, and therefore attempts to create gender equality in this regard. Nevertheless, a piece-meal or "add-on" approach to gender issues (de la Rey & Kottler, 1999) constitutes little towards establishing a policy framework that is determined to foster gender equity. It also highlights that what is left out of the Bill, and why it is left out, has immense implications for gender issues.

Gender-Based Violence

A respondent from an NGO is concerned about the Bill's lack of attention towards gender issues, including gender violence:

> In the preamble to the Bill, the prohibition of unfair discrimination on the grounds of gender, sex, pregnancy and sexual orientation is not included...No mention is made of sexual abuse[4].
> [Respondent from a NGO]

The same respondent mentions that the section dealing with determination of mental health status (Section 12(1)) fails to state that it cannot be determined on the basis of

> Sex, gender, pregnancy or sexual orientation.

Given that "Research has established that women make use of mental health care facilities more often than men", this respondent is concerned that, in the long term, the Bill's neglect of these vital issues will result in continued

> [D]iscrimination and marginalisation of women's issues [and] the potential risk of continued violence against women and the resulting psychological sequelae.

[4] Section 11(1) Exploitation and Abuse, Mental Health Care Bill, 2000.

This important concern is substantiated by research conducted in the USA showing that violence against women (including rape, wife-beating, child sexual abuse) can be considered the single greatest health risk factor for women (Carmen, 1995), and that violence combined with poverty are two central components of the social context of women's mental health (Rieker & Jankowski, 1995). Women experience elevated levels of mental health disorder partly due to violence, poverty and multiple roles (Russo, 1995; Rieker & Jankowski, 1995).

Some of the other important responses from informants in different sectors that bear on gender equity include the following comments. In regards to questions about possible differential impact of the Bill on women and on monitoring implementation from a gender perspective, a department of health respondent comments that

> If the Bill achieves all its objectives, then mental health services should become more accessible. This should benefit women who often do not have the resources to go looking or mental health care in often distant places...Decentralisation of services and early identification [of mental health problems] should benefit women...[the Department, however, has] no specific plans...currently in place to monitor any aspects of implementation. It must still be taken through parliament, regulations still have to be written etc. However, the Department of Health has recently appointed a Director of Gender Affairs. The role of this office is to ensure mainstreaming of gender into all health policies, legislation, etc. It may well become one of the tasks of this office to monitor the Mental Health Care Act when it is passed.

Whereas the national department locates monitoring for gender issues at central level, another respondent from an NGO that participated in the two-year revision process of the Bill feels that

> The Mental Health Care Bill deals primarily with national policy issues...whereas most gender issues occur at the primary health care level and preventive level...gender issues are concerns to be dealt with in the revision of the Health Act[5] which is primarily implemented at the provincial and local level.

This response identifies local level primary health care (PHC) as particularly critical for gender. Further, the Bill provides for integration of mental health care with PHC services. However, it is unclear in what ways prevention and promotion of health would be facilitated at local level, despite prevention and promotion being a fundamental element of PHC. This gap in the policy is further underlined by the results of Gillis et al's (1991) community-based study on the prevalence of psychological illness amongst elderly black persons living in Khayelitsha. According to the study, symptoms of psychological distress, depression and limitation of daily activities were particularly marked amongst the women, where "three-quarters of the women and just over half the men studied had symptoms severe enough to warrant investigation" (Gillis et al, 1991, p. 494).

A further concern for the respondent quoted above is that the provisions in the Bill, especially those dealing with rights, may conflict with provisions in other legislation including

> [L]abour legislation, welfare legislation, and legislation like the Criminal Procedure Act and Sexual Offences Act...We have therefore asked that provision be made for a Code of Good Conduct under the regulations, which explains how the Bill should be interpreted where it interfaces with other legislation.

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[5] The National Health Draft Bill is in its 12th draft (24 May 1998). The Bill, which has been described as the "cornerstone of the country's new health system", was expected to be tabled by the Minister of Health this year. However, it appears that the Department of Health will neither table the Bill nor publish a final draft this year.

Without doubt, it is very important for effective implementation of legislation that an intersectoral approach to the policy making process be vigorously promoted. This is especially important where there is an attempt to redress gender discrimination.

In response to the question about plans to monitor the implementation of the future Act from a gender perspective (See Appendix A: Questionnaire), the same respondent as previously mentioned said that

> The only gender issue thus far identified for monitoring is the effect on men, so far as their involvement in violence is concerned. We believe that a more sympathetic approach to people with mental illness generally will encourage more men to get involved in preventive services, which will have the effect of reducing their involvement in violence.

Protection of Rights: Power Differences

The Bill seeks to protect the rights of users of mental health care services, particularly users who may be admitted involuntarily. However, it is well documented that the ability to exercise rights is partly dependent on gender. Often this is within a context where most women occupy a less powerful position than men do in society. To assume or treat everyone as equal means that the Bill does not take differences of power into account. It is therefore likely that the Bill will not adequately protect women's rights. For example, research into ethics in the practice of psychiatry in South Africa suggests that respondents[6] would be more likely to admit to hospital "female patients who were threatening and when the family demanded action" and that they would be more likely to

[6] The research aimed to determine attitudes with regard to ethics in the practice of psychiatry in South Africa. Questionnaires (sent to all practising psychiatrists in SA in 1993 and 1994) contained three vignettes. For each vignette, multiple choice questions were asked regarding involuntary treatment, management of behaviour problems and psychiatric symptoms, and compliance to demands of family and nurses.

give female patients "medication against their will if they became violent" (Szabo et al, 2000, p. 500). By taking a gender-blind approach to matters such as these, the Bill cannot hope to address nuanced or more hidden gender discrimination, let alone more blatant discrimination.

Curricula and Training

The Bill is silent on the issues of curricula at tertiary level and appropriate training of providers of mental health care. Curricula and training should reflect the shift away from the hospital-based model of care, particularly in a country characterised by immense differences in needs and resources. Moreover, it is an area where attention to gender issues can challenge possible patriarchal, misogynist, and stereotypical attitudes of trainers and providers. The policy process needs to take the lead in advancing this situation, and mechanisms need to be put in place to ensure that real changes are made. A reassessment of the different categories of providers also is essential, especially in terms of a community-based model of care. In this respect, government needs to clarify its position in relation to lay-councilors, many of which most likely would be women.

The implications for gender equity of the Mental Health Care Bill, 2000 are discussed in Chapter 4 in more detail. The next section of this study focusses on a gendered analysis of the Skills Development Act, 1998. The section begins with a summary of the Act.

Summary of the Skills Development Act, 1998

According to government, South Africa has a poor skills profile which inhibits productivity growth[7]. The purpose of the Skills Development Act is to develop the skills of the South African workforce. This entails, amongst other things, to improve the quality of life of workers, their prospects of work and labour mobility; and to improve productivity in the workplace as well as the competitiveness of employers. The Act seeks to encourage employers to use the workplace as an active learning environment. It provides the institutional and financial framework to devise and implement national, sector, and workplace strategies to develop and improve the skills of workers. A "worker" is defined in the Act as an employee, an unemployed person or a work-seeker.

The strategies set out in the Act will be integrated within the National Qualifications Framework in terms of provisions set out in the SA Qualifications Authority Act of 1995, which is seen as a way to promote the quality of learning in and for the labour market. Specifically, the Act aims to employ persons who find it difficult to be employed and to improve the employment prospects of persons who in the past were disadvantaged through unfair discrimination. These disadvantages are to be redressed through training and education.

To achieve its objectives, the Act provides for the establishment of a number of mechanisms and structures, specifically: The National Skills Authority (NSA); the National Skills Fund; a skills development levy-grant scheme; Sector Education and

[7] Department of Labour (1998) Memorandum of the Objects of the Skills Development Bill.

Training Authorities (SETAs); labour centres or job advice centres; and the Skills Development Planning Unit (located in the national Department of Labour).

National Skills Authority (NSA) and SETAs

The National Skills Authority (NSA) is an advisory body, accountable to the Minister of Labour. It has replaced the National Training Board. Government sees the NSA as a vehicle to help overcome, amongst others, the poor strategic focus of skills development in the country; and the lack of coordination within government and between government and the private sector training initiatives. Its core functions are to liaise with the SETAs on policy, strategy and implementation; and to advise the Minister on policy, based on the information it receives from SETAs. Of the NSA's 27 members (appointed by the Minister), five are to be nominated by NEDLAC (National Economic Development and Labour Council). They will have voting rights and will represent organisations of community and development interests. One such appointment must be a woman who represents the interests of women.

The Act provides that the Minister establish Sector Education and Training Authorities (SETAs) for specific national economic sectors[8]. The SETAs replace industry training boards; however, they will not provide training. SETAs are composed of members representing organised labour; organised employers, including small business; and relevant government departments. They will be financed from the skills development

[8] There are 25 SETAs. Examples of sectors include: Banking; Education, Training and Development Practices; Food and Beverages Manufacturing Industry; Health and Welfare; Local Government, Water and Related Services; Primary Agriculture; Public Service; Tourism and Hospitality.

levies collected in their sectors, and from the National Skills Fund. The main function of SETAs is to develop a sector skills plan within the framework of the national skills development strategy. Implementation of the plan requires the establishment of learnerships[9]; approving workplace skills plans; allocating grants to employers, education and training providers and workers; and monitoring education and training in the sector. The SETAs are responsible for ensuring that education and training provided to learners within its sector is of good quality, and is relevant to the sector.

The Department of Labour promulgated other legislation to further the aims of the Skills Development Act. For instance, the Skills Development Levies Act; Regulations Regarding Levies and Related Issues and Regulations Regarding the Funding and Related Issues; and Draft Regulations for Learnerships and Skills Programmes. A series of "Background and Useful Documents" are also available to the public. These documents include reference to Sector Skills Plan Guide; List and Scope of Coverage of SETAs; and 'What Employers Need to Know About the Skills Development Facilitator'. The Skills Development Levies Act sets out the requirements for employers to pay a skills levy. This levy has been set at a rate of 0,5 percent of the leviable amount[10] from 1 April 2000 for a period of one year. From 1 April 2001, the levy rate will increase to 1 percent. The collected levies go towards funding of the SETAs. Only employers who have a payroll of R250 000 or more a year will be required to pay the levy.

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9 A learnership is a structured learning component which includes practical work experience of a specified nature and duration and which leads to a qualification registered by the SA Qualifications Authority. Learnerships must be registered with the Director-General of Labour.

10 The *leviable amount* means the total amount of remuneration, paid or payable, or deemed to be paid or payable, by an employer to its employees during any month.

The Regulations deal with the ways in which SETAs must use the money they receive, as well as employer exemptions and grant disbursements. According to these latter provisions, an employer can receive as a grant disbursement a minimum of 50 percent of the total levy paid to a SETA, subject to providing training in line with national and sectoral skills development plans. The Draft Regulations for Learnerships and Skills Programmes will give effect to the provisions in the Act which deals specifically with these issues (Sections 16 - 21).

Gendered Policy Analysis of the Skills Development Act, 1998

Government hopes to achieve critically necessary and far-reaching changes related to employment prospects and practices through the promulgation of the Skills Development Act, the Skills Development Levies Act and related Regulations. Currently, a high skilled minority (mainly white males) and a low skilled majority (predominantly black females) characterize the parameters of the South African workforce - a legacy of past apartheid laws premised on discrimination based on race, class and gender. The approach to skills development taken in the Act is based on the assumption that meaningful participation in economic and social development, plus individual advancement necessitates rising levels of applied competence. This is seen as especially crucial "given the demands of a more complex and changing economy, characterized by increasing use of information, more complex technologies and a general rise in the skill requirements of jobs" (Green Paper[11], 1997, p. 1).

[11] Department of Labour, (1997). Green Paper: Skills Development Strategy for Economic and Employment Growth in South Africa.

The focus on skills development should deepen individuals' specialised capabilities so that they are able to access incomes through formal sector jobs; through small micro enterprises (SMEs) and through community projects which, in turn, should positively contribute to the economic success and social development of South Africa (Green Paper, 1997). The development of a skilled workforce is expected to compliment the formal education system. The approach is primarily concerned with industry-based training, improving the intermediate level skills base of the country and labour market training for target groups, such as the unemployed, retrenched workers, youth, women, people with disabilities and people in rural areas. Through improving the competence, motivation and adaptability of the workforce and management, the government hopes to strengthen South Africa's ability to function effectively in a competitive global economy. The Green Paper (1997, p. 85) notes that special attention needs to be given to target groups and special measures are to be developed and implemented for these "most vulnerable groups in the labour market". A national skills development strategy is unable to "achieve these measures alone [but] will make an important contribution to reducing race and gender inequalities, including access to training and work" (1997, p. 85).

Add-on Approach: "Women, youth and the disabled"

The Act, however, does not use terminology such as "target groups" or "vulnerable groups". Rather, it refers to "persons who find it difficult to be employed" and "persons previously disadvantaged by unfair discrimination"[12].[13] In this regard, a respondent from

[12] Purposes of the Act, S(1)(c)(iv) and S(1)(e) of the Skills Development Act, 1998.
[13] This may be an illustration of what Friedman (1999) refers to as a disjuncture between the discourse of policy and that of a law. She comments that "it is often at the point where policy is translated into law that

the Department of Labour (DOL) comments that These and other references would cover women and what we refer to as 'designated groups' (women, youth and the disabled).

The same respondent feels that sufficient consideration is given to gender in the Act

> insofar as this is a piece of legislation dealing with skills development in general.

Another respondent from industry comments that

> It was not necessary to address any concerns with regard to gender as the Act makes SUFFICIENT PROVISION for ALL gender related issues. (Emphasis in the original)

This comment seems to substantiate the outcome of a study conducted by the Commission on Gender Equality in 1999 that "the South African business community has little interest in promoting gender equality" (Maharaj, 1999, p. 98).

Gender Equity Means More than a Token Woman

The respondent from the DOL further comments that

> The conceptualisation of the legislation suggests an attempt to redress the imbalances in the labour market from the point of view of skills development and does so with women (and other designated groups) in mind. This is carried through in the representative structures that are intended to govern the implementation of the Act.

Presumably, the structures that the respondent refers to are the National Skills Authority (NSA) and the Sector Education and Training Authorities (SETAs). The core functions and composition of these institutions are discussed above. SETAs are seen by Riley

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gender equality gets dropped" and that this may partly be due to law-makers not "always know[ing] how to conceptualise the policy requirement" (1999: 14).

(1997) as more an administrative device than a vehicle for promoting useful training. Particularly relevant to this analysis, however, is that the Act provides that the NSA is to consist of 24 voting members, and that one of the voting members "must be a woman who represents the interests of women."[14]

This provision seems to highlight what several writers (e.g., Chisholm & Unterhalter, 1997; Mohanty, 1991a; Pandy, Watson, & Makan, 1997) suggest is particularly problematic about a "women *in* development" (WID) approach to gender equity in the field of social development. For instance, that it perpetuates an image of women as a homogenous and coherent group or category prior to their entry into the development process. Newton et al (1999, p. 232) offers a more specific critique of this provision:

> A position [on the NSA] is allocated to a woman to represent the interests of women. Such an approach to gender equity is token. It regards women as a homogenous group whose interests can be catered for by appointing someone of the same sex.

Meer (1999) points out that it is easier to get women on to local or national structures than to institutionalise women's interests in public decision-making processes. She argues further that while it is important to get women onto all levels of government structures, it is equally important to be aware of the differences among women, such as class. Understanding women's interests is a complex issue, and it should not be assumed that "women representatives are...automatically representatives of women" (1999, p. 86).

[14] Skills Development Act, No. 97 of 1998. Government Gazette, Vol. 410, No. 19420, 2 November, 1998, p10.

SETAs: Who Holds the Power

In terms of the SETAs, the respondent from the DOL comments that

> Will the SDA have a differential impact on women? Hard to say. A lot depends on the composition of the SETAs and the interests that are articulated through these institutions.

In terms of the composition of the SETAs, the board of a SETA is composed of equal representation for employers and employees; and professional bodies and bargaining councils are also represented on boards[15]. Special subcommittees or chambers can be set up for NGOs and interest groups. Voting is governed by the constitutions of the SETAs, and constituencies' interests will determine their specific roles in the SETAs. Moreover,

> A skilled nation will reduce the burden on the state because people can create their own jobs and will therefore not be looking for somebody to employ them...Also,...the NGOs will continue to sensitise SETAs to issues which affect groups such as people with disabilities, people in rural areas, different age groupings and SMMEs. (Vlok, 2000, p. 30)

The formal sector is likely to remain the primary focus of the SETAs, although the National Skills Fund established incentives for SETAs to focus on target groups. The different constituencies in a SETA "have an equal responsibility to ensure that their board addresses the needs of those marginal sectors" (Vlok, 2000, p. 30). Some farmworkers and some domestic workers will also fall under SETAs. Other relevant comments from the DOL respondent include that:

> There is certainly a strong emphasis from a policy point of view on redressing labour market imbalances in the implementation of the Act. So, for instance there is a strong push for quotas in learnerships to reflect inclusion of women, youth and the disabled. I suspect the Act will benefit women in terms of greater access to training and job opportunities, although at lower levels of skills.

[15] Vlok, E. (2000: 29) "Interview with Sam Morotoba, CEO of the NSA."

From a gendered policy analysis perspective, much in the above is disturbing. Firstly, in regards to the SETAs, representivity on many boards will be skewed towards structures which are historically dominated by abled-bodied, urban males. These include formal employment, professional bodies and bargaining councils. It will take a strong and well-organised NGO sector to effectively "sensitise SETAs" (Vlok, 2000, p. 30) in relation to the interests of "marginal sectors", (2000, p. 30) especially if this is to be done with little or no recourse to state resources. It is therefore likely that the interests of these constituencies will not prevail. It is difficult to see how particularly impoverished women, such as domestic workers, can hope to benefit from "the composition of the SETAs and the interests that are articulated through these institutions" (comment from a DOL respondent).

Secondly, it is certainly a positive move for learnership quotas to "reflect inclusion of women, youth and the disabled", as the respondent from the DOL suggests. Empowerment or gender equity is not a given, however, by an increase in numbers. There needs to be a concurrent transformation or dismantling of the powerful structures and hierarchies which underpin and sustain the status quo. For example, an increase in the number of appointments of female staff, including black female staff, to the Health Sciences faculty at the University of Cape Town means that female staff now outnumber male staff. But, positions of power are not altered - the highest rung of staff are still predominantly white males while the lowest rung are predominantly black females.

Thirdly, and perhaps most problematic is the respondent's comment that "I suspect the Act will benefit women in terms of greater access to training and job opportunities, although at lower levels of skills." However, the Act does not have any provisions which specifically address the training needs of women; nor does it specify what mechanisms are to be put in place to ensure that access to training is equitable in practice. Moreover, the comment suggests that women who do manage to access training will not be trained for jobs in male-dominated sectors, traditionally higher skilled jobs. This provokes misgivings that when implemented the legislation may hinder rather than benefit women if it effectively "blocks" them from acquiring the same level of skills as their male counterparts. Women need to be trained in areas based on job availability, rather than based on stereotyped ideas of what constitutes "women's work" and "men's work" (Newton et al, 1999, p. 234).

For example, a proposed Department of Labour pilot project to enskill domestic workers in terms of the national Skills Development Strategy (Mail & Guardian, 2000) focuses on training domestic workers for jobs in the hotel industry, dry cleaning and small businesses, jobs largely associated with an extension of women's domestic roles. That this reflects a narrow view of women's work is confirmed by the motivation provided by South African Domestic Workers Union (SADWU) for the project:

> It is important that domestic workers are getting opportunities for training for the first time ...This will be a chance for domestics to increase their skills and learn cooking, how to answer a telephone, baking and looking after children, among other things. (Eunice Dladla, cited in Mail & Guardian, 2000)

A final comment from the respondent from labour does not particularly allay these misgivings:

> Do we monitor from a gender perspective? We certainly will be doing this. We are, however, only starting the process of conceptualising a monitoring and evaluation system, but whatever is put in place will certainly be keeping a keen eye on equity issues.

Summary

Overall comments from the above respondents on the Skills Development Act suggest that they perceive gender issues to be correctly subsumed under an approach that addresses the "bigger picture", effected through terminology that is gender neutral.[16] This is markedly similar to the approach of key actors involved in the process of developing mental health policy. As policy-makers, they appear to assume that a human rights or "add-on" approach to the policy-making process is sufficient to cover or facilitate gender equity. This seems to resonant with Pandy, Watson and Makan's (1997) critique that a WID approach tends to result in marginalised, "add-on" policies, programmes and projects aimed specifically at women. In the end, it effectively omits to deal with gender equity, partly because it fails to pay adequate attention to what is *left out* of the policies.

The analysis provided above strongly suggests that a gendered approach to developing and implementing policy in important sectors is not only insufficient, but that it needs to

[16] The response from the DOL informant above about 'designated groups' [i.e., women, youth and the disabled] indicates, however, that as with the Green Paper, an "add-on" approach to gender underlies the Act.

be prioritised if the ultimate goal of the policy-making process is to "get [it] right"[17]. The next chapter discusses in more detail the implications of this analysis. The argument is substantiated by drawing on predominantly South African theorists writing on issues relevant to this study.

[17] This refers to a comment from a respondent from the Department of Health viz. the Mental Health Care Bill that: "When we get this right there should be sufficient resources in the community to put unnecessary burden on the women care givers."

CHAPTER FIVE
DISCUSSION

Chapter 5 provides a discussion of significant issues and their implications that emerge from the analysis of the previous chapter. The gendered theorisation and policy analysis frameworks discussed in Chapter 2 essentially inform the analysis itself. Thus, this chapter represents a culmination of interconnected conceptualisations that highlight the critical need for a gendered policy analysis. The focus is on implications for gender specifically in regards to the Mental Health Care Bill, 2000 and the Skills Development Act, 1998 but attention is also given to the implications for gender and the policy process more broadly. The results of the analysis in Chapter 3 indicates an important gap in the policy-making process for gender equity.

THE MENTAL HEALTH CARE BILL, 2000: ISSUES TO EMERGE

In regards to the Mental Health Care Bill, 2000 important issues to emerge from the analysis in Chapter 3 include community-based mental health care; the approach to reproductive health and sexual violence; and the Department of Health's approach to gender and health. These issues are discussed below.

Community-Based Mental Health Care: A Central Aim of the Bill

The Mental Health Care Bill, 2000 states that the government must ensure that every organ of state responsible for or impacting on the provision of health services, amongst

others, promotes community-based care, treatment and rehabilitation.[1] According to Strachan (2000, p. 5), the primary purpose of the Bill is to "make mental health a health issue like any other, and not to separate it out as something totally different from other illnesses". The Bill seeks to enable easier access to community services for mental health users, as well as to move people out of psychiatric hospitals and back into the community. Yet, this is not seen as unproblematic:

> The process has already begun, but the [Department of Health] is being very cautious in its approach [learning from] the stark lessons of the US and the UK where patients who were discharged from hospital ended up on the streets or prison. [They] want to do it in a way that [is sure to] work. (Strachan, 2000, p. 6)

The perception is that this approach will lead to an increase in resources and therefore enable widening of the mental health care net. However, proper community facilities have to be set up first, and this means greater community and non-governmental involvement (Strachan, 2000).

Dartnall, Porteus, Modiba and Schneider (2000) conducted a study in the Eastern Cape and KwaZulu-Natal that assessed the service needs of discharged psychiatric patients. Of the group of patients with high support needs (nearly two-thirds of patients), one half reportedly have a family to take care of them on discharge. The families of these patients require training and resources in order to properly care and support them at home. The authors contextualise their study in light of the international perception that care in the community - or deinstitutionalisation - leads to better treatment outcomes and a better quality of life for people with mental health problems. Current proposals to transform

[1] S4(a)(i) and S4(a)(ii) of the Mental Health Care Bill, 2000.

mental health care in South Africa are substantially shaped by this perception, although similar efforts in other countries report mixed results. What is clear is that "cost savings, a major motivating force behind deinstitutionalisation, have not and may not ever be realised" (2000, p. 16).

Dartnell et al (2000) conclude that in order to develop community services for people with mental health problems, additional human and fiscal resources need to be found. Particularly significant in the above comments is that they raise questions about the likely success of the Department of Health's policy proposals for mental health regarding the notion that

> [A]s people are moved into community care settings from hospitals 'the money should follow the patient'. When we get this right there should be sufficient resources in the community to not put unnecessary burden on the women caregivers. In fact it could even produce income-generating projects for women in poor communities.[2]

Although the theory is attractive, the practical implementation of this policy holds many problems. It is not clear that the department of health is able to mobilise sufficient money by downscaling inpatient psychiatric facilities. The bulk of cost in health care relates to personnel, and to save money the Department would have to cutback and/or retrench staff, and this is likely to be extremely difficult to implement. For instance, the efforts to close psychiatric hospitals in the Western Cape met with massive resistance from staff and the public (Mail & Guardian, 11/97) and forced the department to back down on its plan. A most pertinent comment from the article points out that

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[2] This comment comes from a respondent in the Department of Health discussed in Chapter 3.

> Everyone connected with Valkenberg realises that rationalisation is needed, plus better and more efficient accommodation and services. But most also know that closing Valkenberg for a fistful of cash will only exacerbate the crisis of treating mental illness in the Western Cape. (Mail & Guardian, 11/97)

Secondly, even if money is mobilised it is not clear what mechanisms exist to allow money to "follow the patient" and how effective and efficient these mechanisms might be. Most importantly, even if sufficient money were to follow the patient, it is not clear that money that goes into households is going to reach the primary caretakers, i.e., women. There is also no indication that a plan is in place to disaggregate the gender of discharged patients in order to monitor the impact difference of gender may have on the level of care that is received. The gender implications of community-based mental health care are explored in more detail in the next section of this study.

Gendered Analysis of Community-Based Mental Health Care

As discussed in Chapter 2 of this thesis, Klugman's (1999) policy analysis framework is structured around important factors impacting on policy development. These factors include: context, problem identification and solution development, actors, and political process. Moreover, Klugman strongly argues for paying attention to gender throughout the policy-making process. For instance, in the development and implementation of health policy. She maintains that this approach has important implications for policy impact on the health of men and women, and on health services. Klugman further suggests that accounting for gender impact is conducive for ensuring that "health services contribute as much as possible both to good health and social transformation" (1999, p. 50).

However, the approach to community-based mental health care reflected in the Bill fails to adequately account for gender impact in developing policy. This neglect in turn is likely to seriously undermine the capacity of the ensuing legislation to effectively deal with gender discrimination in practice. Comments from de la Rey and Eagle (1997) illustrate this probability. They suggest that, on the one hand, the notion of community is central to mental health care policy in South Africa. On the other hand, a much-needed gendered critique of institutions and norms within communities does not exist within the policy-making process. In essence, this requires that power relations of gender that operate within communities be acknowledged.

The implications of failing to acknowledge power relations are illustrated by a study conducted by Hamber in 1995 (cited in de la Rey & Eagle, 1997). Hamber suggests that elderly women in Soweto comprise the bulk of family care-takers both for psychiatric outpatients and for AIDS-related illness. Women are expected to take on these extra burdens, and the elderly women themselves may not be disinclined to do so. The problem for de la Rey and Eagle (1997, p. 152) is that while the extra work that the women do alleviates "much of the cost of institutionalisation and treatment for the state", it tends to happen within a context of little or no acknowledgement, recognition or support.

The extent to which this additional burden of care impacts on the mental health of the women caregivers does not appear to have been explored in any depth in South Africa to date. However, it would seem intuitive to recognise that such adverse impacts may be

significant, in light of the evidence from research in other countries, presented in the sections that follow.

A study done in the United Kingdom focussing on community mental health services for older women reports a similar outcome (Livingston & Blanchard, 1996). A gap seems to exist between legislation that prioritises the needs of carers and guidelines to achieve this: No financial recompense is forthcoming for the personal, social and financial hardships incurred; nor is the large contribution that informal carers make to the economy generally discussed.

In the United States, public policy on mental illness has been disjointed, and policies that encourage the provision of community-based services do little to establish realistic funding mechanisms (Vandiver, 1997). Community-based mental health care services are structured by the political economies of individual states rather than planned, thoughtful, or empirically based service planning. Fiscal needs, public policies, changing patient populations, and a dismantling of service delivery systems drive institutional and community mental health programmes. According to Vandiver, only "collective action for social change on the part of mental health professionals will reduce the disjointedness of mental health policies" (p. 29).

Livingston and Blanchard's (1996) study shows that the main informal supporters of older people are wives, sisters, and daughters, and that they are likely to provide the care on their own. Scazufca and Kuipers (1996, p. 104) suggest a similar outcome:

> The families of patients discharged to the community have become their major caregivers, and sometimes their only resource...Mothers, sisters and daughters most often function as the carers of mentally ill patients at home...For this reason, Thurer (1993) considered deinstitutionalisation a woman's issue.

Many women may also have to care for more than one family member, while in paid employment. In planning interventions, attention should focus on the fact that while most informal carers are women, they are not a homogeneous group. Single mothers, elderly carers, women who have multiple roles may have different needs for care and support and these should be considered for developing a more comprehensive network of community services (Scazufca & Kuipers, 1996, p. 107). On a similar note, Parker (1996) says that there is a tendency by professionals and policy-makers to perceive carers as an undifferentiated group, with similar experiences, problems and concerns. It may be that most carers find their lives restricted because of their responsibilities; however

> [T]he ways in which these are experienced vary considerably, depending on the relationship to the person being cared for, the carer's age, gender, family, social and economic circumstances, and...the nature of the condition of the person they assist. (Parker, 1996, p. 99)

In terms of informal care in the UK overall, much research focusses on the so-called *double equation* of community care (Parker, 1996). According to Parker, this is translated as "Care in the community means care by the family, care by the family means care by women and that, therefore, care in the community means care by women" (p.100). She points out, however, that it is not easy to determine if there is a differential impact on women who care for people with mental health problems because this area is relatively neglected in this body of research. Parker also raises the important issue of how to ensure that mental health policy also reflects the concerns of persons being cared for, within a

context of moves towards formalizing the role of informal carers. Many younger disabled adults and people with mental health problems may want *assistance* in their daily lives, but not *care*. They further do not want to be forced to rely on assistance from families, friends, or neighbours. There is no guarantee that inadequacies of care and imbalances of power - characteristic of some institutional settings - will not also occur in households. And, since most women experience imbalances of power

> as part of their lives in any circumstances, [they] can thus be *further* disadvantaged when needing 'care' from others. These issues may be even more difficult in the mental health field where interpretations of what is in the best interests of the person with mental health problems are highly contested. (Parker, 1996, p. 101; emphasis in the original)

Research in the USA shows that women provide almost all the care for children and elderly relatives; and that the stress of caring for an aging parent is likely to increase the risk for depression. (Rieker & Janowski, 1995). These authors argue, firstly, that there is a complex relationship between caretaking and women's mental health. Secondly, caretaking can leave women with their own needs unrecognized, unmet, and even unfelt. Caretaking is seen as an involuntary, predictable part of women's behaviour in both the home and in the workplace. It involves strong demands, both externally imposed and internalized by women caretakers, and

> Women develop a compelling sense that care for others is their permanent duty; thus commitment to the work of caretaking has become a 'natural' part of women's sense of self...(Rieker & Janowski, 1995, p. 42)

Moreover, the caring labour of women effectively underpins men's advantage in the labour market, and in the public world more generally (Land, 1994). It is predominantly

women who still do the tasks that are much more likely to interfere with leisure, paid work and career advancement.

Reproductive Health and Sexual Violence

According to de le Rey and Eagle (1997) a gender-sensitive mental health policy needs to seriously consider women's reproductive health concerns, which have both physical and psychological impacts. Policy must also address the gendered nature of sexual violence and its impact on mental health. Examples involving reproductive health discussed by de le Rey and Eagle are post-natal depression (which is widely experienced); and the high incidence of teenage pregnancies in South Africa.

The Mental Health Care Bill, 2000 is silent on the issue of women's reproductive health. On the issue of sexual violence, the Bill contains provisions[3] which prohibits exploitation and abuse of mental health care users, including physical and other abuse. It is not clear what this means in practice, especially in terms of gender. In what ways are women users to be protected against abuse, such as rape, perpetrated not only by other users, but also by mental health care providers? There is no clarity on the ways in which the Bill proposes to enforce protection of mental health care users who may be especially vulnerable to abuse, such as women. The Bill does not provide clear-cut solutions to deal with gendered forms of abuse. Nor is the Bill clear about the ways in which it will prevent abuse on the basis of mental health status, which may also be differentiated along gender lines.

[3] S3(11)(1) and S3(11)(2)(c) of the Mental Health Care Bill, 2000.

Health Promotion

The Bill provides for integration of mental health care services at primary health care level, yet it is unclear what mechanisms are to be put in place to ensure that this happens. This gap in the policy has important implications for health promotion, a primary aspect of primary health care. The study conducted by Gillis et al. (1991) suggests that under severe adverse social conditions, psychological distress and depression may be particularly high amongst elderly black women (see Chapter 3). This outcome is indicative of, amongst other things, a lack of a need of which primary health care and health promotion seems best suited to. For instance, modern approaches to health promotion lend themselves more easily to strategies towards challenging power relations and fostering the empowerment of individuals and communities. Within this enabling framework, issues of gender equity may be easier to articulate and act upon. The Ottawa Charter for Health Promotion and the Jakarta Declaration on Health Promotion into the 21st Century are examples of enabling approaches towards health promotion (Coulson, Goldstein, & Ntuli, 1998). They are built on the principles of:

- Building health public policy
- Creating supportive environments
- Strengthening community action
- Developing personal skills
- Re-orienting personal skills

Department of Health: Approach to Gender and Health

The approach of South Africa's national Department of Health towards gender and health is critical to health policy, including mental health policy. Therefore, for the purposes of this study, it is important to explore current approaches to these issues. For instance,

according to the Director-General of Health[4], health cannot achieve anything on its own and, as such, the Department's role in the status of women is based on the need to deal with equity in access for both women and children. In this respect, responsibilities include community awareness, as well as promoting an environment supportive to the rights of women and children. The Deputy Director-General comments that policy makers and political leaders must provide visible support to programmes aimed at protecting women and children, because without such support, it is not possible to change society's view and attitude that women and children are only tolerated out of necessity. This is true within the sphere of violence against women and children.

These comments coming as they do from officials high up in the ranks of the Department of Health are important, but they also raise complex implications for gender. First, the Department's strategy reflects the Women in Development (WID) approach to gender issues. As mentioned earlier (Chapter 1), WID is particularly problematic in that it is grounded in the assumption that women need to be integrated into or ensured access to development processes. This access is then seen to constitute equity or emancipation for women. Ignored is both the need for fundamental social change in gender relations and the possibility that women might organise to fight for this (Parpart, 1995). Second, De le Rey and Eagle (1997, p. 157) note that a dominant approach to gender within policy development in South Africa is the *women and children* approach: "Each time the category women is mentioned, it is linked to the health of children". Women are

[4] A presentation on "The Department of Health's Role in Implementing National Instruction on Domestic Violence and Problems With Access to Termination of Pregnancy (TOP)" by Director-General: Health, Dr Harm Pretorius, and the Deputy Director-General Health, Dr Eddie Mahlanga, to the Joint Monitoring Committee on the Quality of Life and Status of Women, 19 April 2000.

identified only in terms of their roles as mothers within families, and their own health needs and rights *as women* are overlooked.

Third, Standing[5] (1997) discusses two different approaches to women's health found in the literature: (1) the women's health needs approach, and (2) the gender inequality approach. Briefly, the women's health needs approach highlights the specific health needs of women and girls as a consequence particularly (although not exclusively) of the biology of reproduction. This approach is largely based on the need to provide specific, women focused health care interventions as a basic right in order to address the imbalance of need. The gender inequality approach is centrally concerned with power relations and the ways in which health may be a site of gender conflict. The comments emanating from the Department of Health reflect an approach to health policy that fits into the mold of "women's health needs / women and children", whereas what is needed is to embark on a course which challenges power relations.

THE SKILLS DEVELOPMENT ACT, 1998: ISSUES TO EMERGE

This section of the study further discusses and underscores the importance of the issues to emerge from the gendered analysis of the Skills Development Act, 1998 conducted in Chapter 3.

[5] See Chapter 2, pages 41-42 for more about this.

The Labour Market and Skills Development: A Fair Deal for Women?

The number of jobs in the current South African economy reflects significant job loss (Newton et al, 1999). Moreover, government's macroeconomic policy, GEAR, is seemingly unable to create jobs and to stimulate growth (SANGOCO, 1998). The aim of GEAR was to create 400 000 jobs by the year 2000. But, since 1994, job losses amount to approximately one half a million (Cottle, 1999). Important consequences for government's skills development strategy exist within this context of high levels of retrenchments. For instance, many skilled retrenched workers cannot use their skills due to lack of jobs and/or due to lack of access to resources needed to start their own businesses. Women are particularly at risk in this respect, and government needs to develop gender-sensitive policies and to target job creation for women (SANGOCO, 1998).

A shrinking labour force usually hits younger women and men harder than older ones, despite higher levels of education of the former (Newton et al, 1999). Nevertheless, in all age groups, unemployment is higher for women than for men. The types of jobs that women occupy in the workplace mean that they are most likely to be retrenched. Women tend to work in so-called "elementary" occupations (1999, p. 221). Statistics show that 35 percent of all employed women and 45 percent of African women worked in these generally low-paid occupations in 1997. While women are concentrated in relatively few economic sectors that are low pay, men are more evenly spread across a wider range of sectors (Budlender, 1999). Men predominate in all sectors except in services.

Even if large numbers of women could find jobs in the informal sector, which is debatable, they are unlikely to be the first choice for well-paid and sustainable employment opportunities (Newton et al, 1999). Further, it is very difficult to repair the social damage caused by grinding poverty due to large-scale retrenchments, even if economic growth is generated and new jobs emerge (Head, 1998). Retrenched workers may also be left with no marketable skills with which to secure alternative employment after their retrenchment.

Added to the above is a lack of gender disaggregated statistics on the number of women and men in formal employment[6]. Further, official definitions[7] of what constitutes unemployment or work, or a worker in South African legislation are problematic (Newton et al, 1999), especially in terms of *who* gets excluded in the definition. Definitions of work tend to exclude and underestimate much of women's work (Masika & Joekes, 1996). The practical effect of the exclusion is that a large number of women are invisible to labour market policy and employment law and hence deprived of employment rights (Madonsela, 1995). To include domestic workers, mainly African and coloured women, in official statistics as part of the informal sector when there are so many (nearly twice as many as other categories) can be misleading both for the domestic workers and policy-makers.

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[6] Newton et al., 1999. The government's statistics bureau - Statistics SA - only asks employers for the total number of employees, and not how many women or men are employed.

[7] ibid. A strict definition for unemployment is one which includes only people who are looking for a job. An expanded definition for unemployment includes all people who want a job even if they are not actively looking.

Sticking to a strict definition of unemployment may mean that policy-makers get a warped picture of South Africa's unemployment problem. Use of an expanded definition, on the other hand, may focus government's "attention on women living in rural areas" (Newton et al, 1999, p. 218). It may also make government aware that the many people who do informal or subsistence work do so because of lack of other job opportunities and they see themselves as part of the unemployment problem. Added to all this, but largely hidden, is the

> unpaid work which women, children and men perform each day in bearing, rearing and caring for children and looking after the needs of other family member. (Newton et al, 1999, p. 214)

All of this has serious implications for the policy process. The tool that government uses to determine unemployment rates and how they define work obviously has implications for targeting the unemployed for training, as the Skills Development Act proposes to do. Implications for gender equity in training are evidenced in the government's October Household Survey for 1994 - 1997 which shows a major discrepancy in access to skills training between men and women (Newton et al, 1999).

Another example is that a high percentage of women participated in textile and clothing sector training programmes, yet these sectors are particularly hard hit by government's economic policies (Samson, 1997) and large numbers of women lost their jobs in these industries. This means "the SETAs and the NSA will need to target women for skills training, particularly in male-oriented sectors" (Newton et al, 1999, p. 233). If this is not to be the case, as a respondent from the Department of Labour suggests (see: Chapter 3),

then working class, uneducated, unskilled women will continue to face multiple barriers in accessing the formal labour market. As Friedman (1999) argues, the way a problem is named or defined in terms of gender has significant implications in determining the forms of intervention and assumed beneficiaries.

Moreover, sufficient funds are required to effectively implement and monitor new labour policies, including the Skills Development Act, 1998. It is unclear whether the department's budget is geared to do this.

Gender Bias, Gender Segregation in the Labour Market

Due to the socio-economic nature of many of the labour market inequities, labour legislation alone is not a panacea for gender equity (Nyman, 1997). Gender bias in the labour market embodies a myriad of factors. Gender issues may be confined to concerns with parental rights, such as with women as mothers and other important issues are not tackled. For instance, sexual harassment, pay equity, social security, and health and safety (Madonsela, 1995). Women must also deal with unpaid childcare and household work, and bias in access to skills training (Baden, Hassim and Meintjes, 1998). There is gender segregation by industry and occupation, which in practice means that women have fewer job choices, earn lower wages, and far less access to skills training for better paid jobs.

The wages gap between men and women is not caused primarily by differences in education and skills. Rather, it is largely due to women being more often in low paid

occupations than men, while the differences in the wage rates between occupations is not explicable in terms of skill or training (Walby, 1988). In South Africa, women earn less than men in the formal and informal sectors, and job segregation remains between the jobs that men and women do (Head, 1998). Baden, Hassim and Meintjes (1998) suggest that there is no practical value in outlawing wage discrimination along gender lines if there is ongoing and sustained segmentation of the work force based on gender. The above comments tend to corroborate Masikika and Joekes' (1996) suggestion that increased access to employment and income for women does not readily translate into an improved status or bargaining power for women.

Gender segregation at work is extraordinarily resilient to economic crises, restructuring and technological revolutions (Cockburn, 1988); and it persists through profound changes in the wider social order of class and gender relations (Middleton, 1988). Race and ethnicity is often also a basis of segregation, so that black women are more discriminated against in terms of access to decent jobs and pay than any other group of women. In Britain in the late 1980s, persistent racism faced by black women denied them the possibility of breaking out of gender-specific and ethnically segregated low-pay labour markets (Phizacklea, 1988). Nyman (1997) says that black women in South Africa are concentrated in low-paid and unskilled jobs, and that their need for legislative protection is paramount:

> [Black women] are located in sectors that are difficult to organise, such as the informal sector, in non-standard employment (e.g., part-time, casual and temporary work, piecework and contract work). As a result, most women workers are not organised into trade unions and will not enjoy an improvement in their positions through collective bargaining. (Nyman, 1997, p. 3)

Important obstacles to organising women include that labour market policy conceptualises women as comprising part of the pool of reserve labour, and their income as supplementary to that of male workers (Nyman, 1997). A similar point is made by Taylor (1997) who suggests that women's low wages is due to the assumptions that women workers not only supplement the income of their male partners, but that most breadwinners are male. She argues that both these assumptions are incorrect, and that women's income is essential to household survival "since women allocate proportionately larger amounts of their income to children's survival needs" (1997, p. 24).

Madonsela (1995) suggests that, on the one hand, collective bargaining improves the position of *all* organised black workers, including black women workers. On the other hand, collective bargaining has serious gender limitations. For instance, women tend to be located in industries where they are excluded from the bargaining unit. She further argues that to the extent that collective bargaining focuses on women, it tends to be on women as mothers. According to Madonsela, trade unions often adopt a reactionary stance on gender issues. Both leaders (male-dominated) and members tend to perceive women's demands as a threat to their own privileges. Madonsela argues that union support for wages and retention based on seniority operates to disadvantage women as new entrants to the labour market generally or in certain occupations. Further, union backing for across-the-board percentage increases in pay widen the gap between the better paid who tend to be male and the poorly paid who tend to be female.

Does South Africa Need Skills Development?

> [T]he potential of training to promote transformation and gender equity depends not only on how gender is conceptualised but also on the politics of the broader framework in which the training programme is embedded... Education and training are never neutral. They are tools which will yield results intended by those who control them. (Samson, 1999, p. 16).

For the most part, skills development policy in South Africa is based on the same assumptions as GEAR; that is, both are informed by the need to make South African industry competitive in order to ensure economic growth (Vally, 1997). Government sees skills development as contributing to the development of new industries; helping to make existing industries more profitable and competitive; and helping other industries to find new niches (Bird, 2000). A principle underlying the skills development strategy is that it should be demand led which means that training should be driven by demand for particular skills across the economy (Macun, 2000). This strategy should maximise job security and access to jobs. Macun sees an effective planning cycle for skills development influenced both by inputs "from below" (e.g., workplace skills plans) and by national strategy inputs - the "top down" element (p. 42).

Job security and creation, and economic growth are seen as vehicles to adjust the skills profile of South African labour to meet the competitive demands of the global economy (Ray, 1998). Government perceives that, amongst others, a market dominated economy, active labour market policies and a more responsive education and training system are pivotal for addressing social and economic problems in South Africa. A major concern for Ray is that the competitive thrust of the policy is likely to lead to

> a situation where the majority of workers will be trained for unemployment. Employers, on the other hand, stand to gain from an abundance of skilled and mobile labour in the labour market. (Ray, 1998, p. 40)

Vally (1997a) argues, firstly, that the notion of skills, and especially skills shortages, is a contested one. Secondly, he says that learnerships may increase employability, but are unlikely to increase the number of available jobs. On the other hand, Kraak (1997, p. 78) debating Vally, suggests that new policy to develop skills is a "demand-led enterprise training policy which is underpinned by appropriate supply-side measures." This means that the policy both is responsive to employer skill needs, and that is also includes important supply-side measures such as structured learnerships. According to Kraak, the Green Paper[8] consistently displays concern for "the plight of the most vulnerable groups in South Africa - the rural poor (especially women), youth, informal sector workers, the unemployed, and people with disabilities" (1997, p. 80).

In response to Kraak (1997), Vally (1997b) reiterates that GEAR calls for a skills strategy to promote international competitiveness by focussing on the growth sectors of the economy, and that the Green Paper defers to this aim. "Supply-side measures" are deficient in that mechanisms to meet the needs of the so-called target group are not set out. [Neither are they set out in the Act, with concurrent implications for gender.] Learnerships are the major vehicle to address skills development needs, but they prioritise the formal sector and are based on demand-led training. Most of the target groups therefore "will be excluded from even reaching the entry level of the system"

[8] Department of Labour, (1997). Green Paper: Skills Development Strategy for Economic and Employment Growth in South Africa.

(1997b, p. 84). The Green Paper [and the Act] lacks measures to address discrimination against women and the disabled and the barriers they face, such as lack of child care facilities and transport, which hinder their access to training. Measures to combat the general "stigmatisation" of workers by age, sex, and race are also not discussed.

Women Get No Joy from GEAR

GEAR'S proposals for economic growth lack a gender perspective (Taylor, 1997). Government conceptualises economic growth as "projected increases in employment opportunities, increases in revenue and resultant decreases in government debt" (1997, p. 13). But, such conventional indicators do not accurately reflect *who* and *which groups* will ultimately benefit because growth in GDP and per capital income (PCI) is usually no indication of a change in the lives of poor people, especially women. There is no "trickle-down" effect envisaged by the developers and supporters of GEAR to promote the development of the poor and to benefit women (Joint Committee on the Status of Women, 1998).

Government made no effort to look at the impact of GEAR on gender issues, or whether gender equity *is* compatible with GEAR's penchant for globalisation and international competitiveness (Samson, 1997). Women's position in the economy is affected by several key factors. Firstly, women's unpaid work in the home, while underpinning the economy, is not beneficial to women because it is not taken into account in economic and development policies. Secondly, many institutions that link people to the job market are biased against women, because of gender-stereotyping. This stereotyping leads to

women's unpaid work and paid work being linked; i.e., seen as "unskilled women's work" which perpetuates their exclusion from more lucrative employment opportunities (Samson, 1997, p. 10). Taylor (1997) similarly argues that women and girls who perform non-market and non-monetised home-based tasks (such as collecting firewood, fetching water, growing or procuring food for the family, cleaning the house, caring for children, the elderly and other dependants), and who are responsible for reproduction are termed "economically inactive". Or, their economic activity is underestimated because "hidden" and not reflected in official statistics (Baden, Hassim, & Meintjes, 1998).

Globalisation of production further disadvantages women's position in the labour market, as can be witnessed by the increasing closely-related phenomena of flexibility in production and employment practices (Samson, 1997). Essentially, this entails retaining a small core of workers who have access to basic labour rights. Samson argues that these workers are supported by peripheral workers in non-standard or atypical jobs who usually have no rights: "Across the globe it is mainly men who are retained as core workers, and women who are pushed out into the more exploited periphery" (p. 11). Indications are that South Africa is no exception as GEAR both calls for increased flexibility in the labour market, and expects an increase in non-typical forms of employment. It seems likely, Samson argues, that this will mean women workers will increasingly be pushed into non-permanent and insecure jobs.

Unterhalter (1999) discusses the large body of feminist critique on the economic opportunities that accompany globalisation. For example, reference is made to the very

low wages and highly exploitative conditions of work; the scarce opportunities for unionisation; and the intensification of women's subordination in the household, even if they are wage earners. There appears to be consensus amongst many feminist writers that overall economic globalisation has not delivered on promises regarding women's emancipation. This seems to be substantiated by a report on the Sixth African Regional Conference on Women (November, 1999) where speakers from, amongst others, Kenya, Zimbabwe, South Africa, Ghana, Burkina Faso, and Senegal say that globalisation tends to further marginalise women and increase their poverty (Hagos, 1999). For most women in these and other African countries, globalisation means exploitation as cheap labour, neglect and ignoring of their contributions, and fewer resources allocated to health and education. The report says that the 1999 world survey on the role of women's development during post-Beijing[9] suggests that the impact of globalisation on women's employment in developing countries is striking:

> Africa [is] the only region in which women's employment had not grown substantially faster than men's...This has resulted in a striking increase in the number of female-headed households...particularly in sub-Saharan Africa where women now headed approximately 30 percent of households. (Hagos, 1999, p. 1)

The complexity of implementing legislation promoting skills development for women within a framework of an export-oriented economy such as GEAR is highlighted by international research which suggests that a nation's competitive edge is often based on women's disadvantage in the labour market (Samson & Valley, 1996). These authors argue that:

> Training which promotes higher wages for women, and for black workers in general, will...compromise the competitive edge of many sectors of the

[9] Fourth World Conference on Women, held in Beijing, China in 1995.

> South African economy which rely on a low-wage strategy. (Samson & Valley, 1996, p. 24)

Skills Development: An End to Gender Discrimination?

According to Samson (1999) the Skills Development Act is completely gender-blind. She argues that the Act prioritises training for competitiveness and productivity, which is in line with the skills development planning in GEAR. Any positive effect on gender equality resulting from the Act will either be accidental or the result of concerted struggle. Samson points out that the employment prospects of women who get education and training for skills development may improve but that structural discrimination in the labour market and elsewhere in society is likely to prevent them from getting jobs commensurate with the level of skills acquired. She notes that in 1995 only 22 percent of African women with the same level of education as African men were employed.

Samson (1999, p. 14) further argues that the Skills Development Act (1998) is unlikely to redress "either discrimination in general or gender discrimination in particular". The only reference to women in the Act is the one which refers to the composition of the National Skills Authority - that out of the five community representatives, one must be a woman who represents women. Thus, not only are women seen as an homogenous category that must be represented separately by a woman/women who can speak for all women; but, all other stakeholder are also "freed from the responsibility for addressing gender issues in their constituencies" (1999, p. 14). Neither women nor the informal sector are granted a seat or form of representation on the SETAs. It is difficult therefore to see how the SETAs will meet their objective to specifically address the training needs of women and

the informal sectors. Although the targeting of women, the informal sector and the disadvantaged is likely to be prioritised in the National Skills Plan, there are concerns that these priorities will be subordinated to those of promoting exports and foreign direct investment, as was done in the Jobs Summit Declaration (Samson, 1999).

POSSIBLE IMPACTS / LINKS BETWEEN THE BILL AND THE ACT

There are possible impacts that mental health policy and skills development policy may have on each other. For instance, problematic issues in relation to the Mental Health Care Bill, 2000 are discussed in the first section of this chapter. Even if it is possible for government to satisfactorily address these issues, the policy may still be unable to meet its objectives in the implementation phase. This may occur if mental health care users in communities continue to be discriminated against, and especially in terms of accessing formal employment (Modiba, 2000).

Modiba (2000) argues that negative attitude and stigma towards mental health care users is still strong in South African communities. Moreover, while work is identified as "one tool to promote community integration of persons with mental illness" (p. 13), discrimination towards mental health care users appears to be a major impediment to their adjusting to work. Within this context, Modiba asks whether implementation of the Employment Equity Act (1998) can, as it proclaims, promote equal representation of "previously marginalised groups, such as women, mentally and physically disabled, at all levels of the open labour market" (2000, p. 14).

The Department of Health thus proposes policy to integrate mental health care users into communities, presumably to live productive and meaningful lives. But, partly due to facing unfair discrimination in the communities and at the workplace, many will struggle to do so even though there is legislation in place that prohibits this discrimination and promotes equal employment opportunities. It may also transpire that discrimination hinders mental health care users' ability to access structures set up by the Skills Development Act which train on the job, such as learnerships, although the Act purportedly targets "persons who find it difficult to be employed" and "persons previously disadvantaged by unfair discrimination". Moreover, as Modiba (2000) points out, this is to be done within the broader macroeconomic framework of jobless economic growth.

All of this highlights that the policy-making process is deeply complex and intrinsically interconnected on many different levels. As Walt (1994) points out, the state makes political decisions which affect the policy decisions and implementation of policy at department or sector level. For instance, the above sketch suggests that macroeconomic policy (i.e., GEAR) places constraints on implementation of health and labour policy. One consequence of this may be that enabling provisions of policy meant to promote human rights does not reach those who need it the most and who may most benefit from it. Yet, at times policy decisions at department level seem to reflect a less than adequate consideration of these constraints, and this cannot be lightly overlooked.

In terms of gender considerations, this thesis argues elsewhere (see Chapter 3) that the Mental Health Care Bill, 2000 and the Skills Development Act, 1998 differentially impact on gender. For instance, women already face discrimination in the workplace (Commission on Gender Equality, 1998). Women also make up the bulk of mental health care users; therefore as women with mental health problems, they are more likely to face discrimination in accessing and keeping jobs than men with mental health problems are. Implementation of the Skills Development Act, 1998 may in effect hinder many women from acquiring higher skills, especially in the male-dominated sectors.

CONCLUDING REMARKS

The main purpose of this study is to conceputalise and argue for a gendered approach to policy analysis. This has been done through exploring theory and analysing specific policy using a gender lens, and then linking the two processes. In the next, and final, chapter of this thesis specific recommendations, suggestions for further research and concluding remarks based on the outcome of this process are provided.

CHAPTER SIX
RECOMENDATIONS, FURTHER RESEARCH, AND CONCLUSION

A gendered analysis of the Mental Health Care Bill, 2000 and the Skills Development Act, 1998 highlights a policy-making process that significantly lacks adequate consideration of gender issues, their implications and consequences. The outcome of the analysis suggests that to achieve broader goals of equity, gender impact needs to become an intrinsic aspect of policy development and implementation in South Africa. If this does not become a priority in the policy-making process, stated goals and objectives are likely to remain rights on paper only. This thesis also highlights areas of weaknesses in the policy process where a shift in approach could make a significant difference. It is within this framework that the following recommendations and suggestions for further research are proposed. Some of the recommendations draw on the work of other writers, but remain authentic to the researcher's own "voice".

RECOMMENDATIONS

General Recommendations

- Policy makers across sectors must recognise and address inappropriate approaches to gender in their formulations. For instance, they must guard against approaching gender as if it does not exist (the gender-blind approach). Where gender is included in the policy-making process, it should not be limited to an add-on or "women and children" approach. Rather, policy makers should adopt an integrative approach to gender in formulating policy (de la Rey & Kottler, 1999). For example, the

nomination of a token woman to "represent" women as a category should not be acceptable practice.

- Gender training workshops of policy makers, policy implementers and public servants should be integral to any policy process, especially in light of the above.

- Significant "gaps" in the policy-making process need to be focussed on for a better understanding of gender impact. It is recommended that independent bodies, such as the Commission on Gender Equality, address:
  - Disjunctures between the discourse of policy and the discourse of a law
  - Disjunctures between policy objectives and allocated resources
  - Separation between policy makers and policy implementers (Friedman, 1999)

- Government departments should put in place mechanisms dedicated to monitoring and evaluating all legislation for gender impacts and should plan for such structures in the development of the policy. Findings should be reported back to relevant public servants and legislators on an ongoing basis. Departmental units dedicated to monitoring gender impacts of legislation must ensure meaningful representivity on legislated structures.

- Civil society (including NGOs, CBOs, and target audience) needs to have greater input into the policy making process. But this should be a meaningful activity for all stakeholders, including government. A commitment to training and capacity-building

is essential to enable stakeholders to engage in the policy process from an informed position. Gender issues have to be an integral part of this process. This strategy implies a collaborative relationship between civil society organisations and government. The role of government will be to facilitate this collaboration.

- A "shadow report" that monitors government's commitment to gender equity in the policy-making process (i.e., that government does what it says it intends doing) could be produced through collaboration between civil society organisations and independent government institutions involved in gender work.

- In order to better avoid key potential weaknesses in legislation, research that evaluates the likelihood of, and potential obstacles to implementation should inform policy and legislation.

Recommendations for the Mental Health Care Bill, 2000

- The Bill moves towards a health rights approach to mental health care services. However, the Bill does not address gender (even though research[1] suggests that there are significant differences in current psychiatric treatment practices in South Africa along gender lines). Before the Bill is legislated as an Act, it needs to be amended to include gender. Omitting gender means that the Bill cannot really meet its commitments towards achieving human rights for mental health care users.

[1] Szabo et al, 2000.

- The Bill also should either be amended to take a broader view (beyond the rights of people in health establishments) or it should be renamed. If the Bill is amended, it needs to provide a framework where community-based care is gender aware and where prevention is able to reduce the disproportionate burden borne by women. This implies careful consideration of the impacts on communities and especially impoverished women in communities. If the Bill is not amended, given its essential focus on hospitalised users, perhaps it should be renamed "The Mental Health Care Patients' Rights Bill".

- Implementation is one of the key potential weaknesses of proposed mental health legislation. Therefore, before the Bill becomes an Act significantly more research needs to be conducted to inform implementation feasibility and the best methods for implementation.

- Health care professionals, psychologists, counsellors and social workers need formal training towards understanding gender and its relationship to mental health. This also should be included in undergraduate and postgraduate curricula of these professionals. The training could be linked to the Department of Health commitment to a Patients' Rights Charter.

- The Bill is silent on many critical issues that need to be addressed, including reproduction and mental health, sexual violence and gender, and sexuality, sexual

problems, sex work and HIV/AIDS (de la Rey & Eagle, 1997). Amendments to address these gaps should be a priority for revising the Bill.

- If the Bill seeks to protect the rights of mental health care users, mechanisms need to be set up to empower mental health care users to know and to exercise their rights. Examples include patient education, provision of information and establishment of user groups. Such methods to achieve patient empowerment need, however, to be informed by an awareness of gender differences.

Recommendations for the Skills Development Act, 1998

- The Skills Development Act could be amended to take gender into account. For example, membership of all of structures provided for in the Act should be revisited and made more representative. This is especially important for marginalised women. The Department of Labour (DOL) should provide guidelines to avoid tokenism in representation. The Department should also establish a mechanism (perhaps a unit) dedicated to oversee representivity of structures in relation to gender.

- The gap between the intention of the Act to include the informal sector and the mechanisms by which this will be done needs to be addressed. More research around implementation needs to be conducted to show how this will be done and how it will benefit gender equity.

- The national Skills Development Strategy should actively seek to ensure that women and men receive training in skills other than those traditionally associated with their respective gender roles. For example, skills provided to domestic workers should seek to move them out of the most marginalised sector into higher skilled, more secure and better paid jobs.

- There should be ongoing monitoring of the implementation of skills development legislation by government *and* civil society, focussing on impacts for gender. Policy makers in the DOL should get feedback from the monitoring process. Structures, such as the Commission on Gender Equality or a departmental gender unit should ensure that policy makers act on the feedback. The same structures could monitor for the effect of synergy (e.g., with the Employment Equity Act) on gender. For instance, a focus could be on whether women are getting the jobs for which they are trained.

- Government needs to face up to the current reality of jobless growth. There seems little point in a massive exercise to raise the country's skills level if macroeconomic policy prevents those benefiting from the Act from getting jobs. Government needs to ensure job creation through its macroeconomic framework, and gender equity needs to be a priority objective.

Recommendations Common to Both Policies

- When monitoring is done for gender impacts of legislation, it should be done across sectors. That is, it should take account of the ways in which implementation of

different policies from different departments interact (for example, Labour and Health) to promote or hinder gender equity.

- Similarly, policy development should take account of synergistic effects and impacts, especially in the area of social development.

Future Research

- This thesis has focused on two pieces of policy in order to provide an in-depth analysis. What would be a very useful complementary approach would be a comprehensive audit of all post-1994 health and social development legislation for gender impacts. Such an audit would have a broader but less in-depth approach with regard to:
  - Looking comprehensively at the scale of the problems encountered
  - Making comparisons between policies and laws
  - Assessing trends
  - Identifying gaps
  - Identifying weaknesses and strengths

Out of such research, a set of guidance documents for the policy making process (some for policy makers and some for civil society, etc) could be produced. The research could also be used to inform workshops and training (similar to the Women's Budget Initiative).

- Follow-up research on the implementation of the Mental Health Care Bill, 2000 and the Skills Development Act, 1998 should be conducted to assess whether the assumptions underlying the policies are borne out; how impacts are distributed by gender, etc.

- Research could also usefully be conducted into the capacity to engage with gender, and the approach of government and civil society organisations to gender in the policy making process. Questions posed could include: How important do organisations doing gender work think it is to make input on gender to policy processes? Are there other strategies that they may prefer in order to achieve gender related goals?

CONCLUSION

Gender equity is key to achieving the goals of the legislation. However, it is not something that automatically occurs in the implementation of policy because a rights-based or "add-on" approach to gender is adopted in the policy process. Gender equity also requires recognition that male domination or an imbalance in power between women and men underlies the discrimination based on gender that makes women, and especially women with few resources, "persons who find it difficult to be employed" and "persons previously disadvantaged by unfair discrimination" (Skills Development Act, 1998, S(1)(c)(iv); S(1)(e)). Power differences also mean that predominantly marginalised women are most likely to bear the brunt of often unintended consequences of implementation of policy. For example when they effectively remain unskilled or under-

skilled compared to their male peers, and when they become the main caretakers of deinstitutionalised mental health care users.

Where health and social development policy and legislation does not take account of the differential gender impact, the implications are likely to be substantial not only for women, but also for others, given women's role as primary caregivers. Existing gender inequities may be accentuated by an inadequate attention to gender in the policy process. Provisions in the Mental Health Care Bill and in the Skills Development Act indicate that there is insufficient understanding by some policy-makers about the complexities involved in promoting gender equity. They may even reflect a lack of political will to deal effectively with gender issues. Finally, the statement that the policy process continues to pose a serious challenge for gender equity remains "true".

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APPENDIX A

COVERING LETTER / QUESTIONNAIRE

Covering Letter

Dear

I am conducting research on the gender implications of the [Skills Development Act, 1998] [Mental Health Care Bill, 2000] towards a Masters in Women's and Gender Studies at the University of the Western Cape. The research is also connected to my work as a policy analyst for the Public Health Interventions through Legislative Advocacy (PHILA) programme, which is national programme of the National Progressive Primary Health Care Network (NPPHCN).

I am at the stage of collecting data, and would really appreciate it if you would respond to the questions set out below. All data collected will be strictly confidential. If it is not possible for you to do this, perhaps you could recommend people I could contact in this regard.

Responses can be either faxed or emailed to me, or by telephone. If you would like more information about this study, please do not hesitate to contact me. I would appreciate it if responses reach me by the 15th of June.

Thank you very much.

Phyllis Orner
Tel: 021 448 8702
Fax: 021 447 0624
Email: phyllis@philaw.co.za

Questionnaire

Government Officials

Mental Health Care Bill, 2000

1. Was there any consideration of gender in the process of developing the Bill?
   Please elaborate.
   Do you think consideration of gender was sufficient?

2. Was the Commission for Gender Equality consulted in the development of the Bill?

3. Were any gender NGOs consulted in the development of the Bill?

4. In the Act's future implementation, do you think that the Act will have any differential impact on women? (Short-term and long-term)
   Please elaborate

5. Does your department plan to conduct any monitoring of the implementation of the Act from a gender perspective?
   Please elaborate

Skills Development Act, 1998

1. Was there any consideration of gender in the process of developing the Bill and/or Act?
   Please elaborate.
   Do you think consideration of gender was sufficient?

2. Was the Commission for Gender Equality consulted in the development of the Bill/Act?

3. Were any gender NGOs consulted in the development of the Bill/Act?

4. In the Act's implementation, do you think that the Act has any differential impact on women? (Short-term and long-term)
   Please elaborate

5. Does your department conduct any monitoring of the implementation of the SDA from a gender perspective?
   Please elaborate

Industry, Trade Unions, NGOs

Skills Development Act, 1998

1. Do you think the Act pays sufficient attention to issues of gender?
   Please elaborate.

2. Did you make any submissions about the SDA? Were any of your concerns related to gender?
   Please elaborate.

3. In the Act's implementation, do you think that the Act has any differential impact on women? (Short-term and long-term)
   Please elaborate

4. Does your organisation conduct any monitoring of the implementation of the SDA from a gender perspective?
   Please elaborate

Mental Health Care Bill, 2000

1. Do you think the Bill pays sufficient attention to issues of gender?
   Please elaborate.

2. Did you make any submissions about the Bill? Were any of your concerns related to gender?
   Please elaborate.

3. In the Act's future implementation, do you think that the Act will have any differential impact on women? (Short-term and long-term)
   Please elaborate

4. Does your organisation plan to conduct any monitoring of the implementation of the Act from a gender perspective?
   Please elaborate