Facing the Future Together

Adolescent girls, Kwazulu-Natal, South Africa
UNICEF/HQ01-0287/ GIACOMO PIROZZI

Report of the United Nations Secretary-General's Task Force on Women, Girls and HIV/AIDS in Southern Africa

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PREFACE

"We must make sure that girls –- who run a particular risk of infection -- have all the skills, the services and the self-confidence to protect themselves. Across all levels of society, we need to see a deep social revolution that transforms relationships between women and men, so that women will be able to take greater control of their lives -- financially as well as physically. And we must encourage men to replace risk-taking behaviour with taking responsibility."
- Kofi Annan, United Nations Secretary-General[1]

As early as the 1980s, development workers and gender activists were beginning to recognise that HIV/AIDS would have especially severe implications for women. By the middle of the decades, the Society for Women and AIDS in Africa (SWAA) was beginning to mobilise women in the fight against AIDS.

By June 2001, it was clear that women, particularly in Africa, were beginning to strain under the pressure of high infection rates and increased workloads due to AIDS. The United Nations General Assembly Special Session on HIV/AIDS declared that "women and girls are disproportionately affected by HIV/AIDS" and committed UN member states to a set of actions to reduce the impact on women and girls, and promote and protect their human rights.

A year later, at the Barcelona International AIDS Conference in July 2002, Stephen Lewis, the United Nations Secretary General's (UNSG) Special Envoy on HIV/AIDS in Africa said,

> *"The toll on women and girls is beyond human imagining; it presents Africa and the world with a practical and moral challenge, which places gender at the centre of the human condition. The practice of ignoring gender analysis has turned out to be lethal… For the African continent, it means economic and social survival. For the women and girls of Africa, it's a matter of life or death."*

It was a plea that went largely unheard.

In January 2003, Mr. Lewis, accompanied by James Morris, Executive Director of the World Food Programme and the UNSG's Special Envoy for Humanitarian Needs in Southern Africa, visited Lesotho, Malawi, Zambia and Zimbabwe in a joint effort to tackle the unprecedented humanitarian crisis in southern Africa caused by the interlinkages between HIV/AIDS, food insecurity and weakened government capacity.

Their mission report highlighted the impact of the crisis on the women of southern Africa, stating that "very little is being done to reduce women's risks, to protect them from sexual aggression and violence, to ease their burdens or to support their coping and caring efforts."[2] The envoys recommended that an "immediate, strongly led and broadly implemented joint effort to take action on gender and HIV/AIDS must be initiated without delay. The effort should feature leadership from the United Nations, the active engagement of governments and substantially increased support to civil society organisations, including remarkable grassroots initiatives."[3]

The Establishment of the Task Force

This time, the call to action for Africa's women was heard. The United Nations Secretary General immediately requested UNICEF Executive Director Carol Bellamy to set up a Task Force to respond to this recommendation.

A planning meeting in Johannesburg, South Africa, bringing together global, regional and country level representatives from the United Nations, resulted in Terms of Reference for the Task Force focusing on six issues, within a broad gender framework (see Annex 1):

1. Prevention of HIV/AIDS among young women and girls
2. Girls' education
3. Violence against women and girls
4. Property and inheritance rights of women and girls

5. The role of women and girls in caring for those infected and affected by HIV/AIDS
6. Access to HIV/AIDS care and treatment for women and girls

It was agreed that the Task Force would focus on the nine countries in southern Africa most severely affected by HIV/AIDS – Botswana, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Zambia and Zimbabwe. The Task Force Terms of Reference set out a process designed to ensure that a wide range of stakeholders in each country were included in consultations and meetings.

Task Force Members and Working Group
UN country teams in these countries were asked to nominate eminent persons, activists and leaders from government and civil society to serve as Task Force members. As a result, the Task Force comprises 27 women and men living and working in southern Africa, who are actively engaged in policy-making, programme implementation and community mobilisation (See Annex 2).

During the course of its work, the Task Force has been assisted by a working group based within the regional team of the Joint United Nations Programme on HIV/AIDS (UNAIDS) in Pretoria, South Africa. This working group of four resource people, led by a UNICEF staff member, has drawn on the technical support of regional representatives of the United Nations Development Fund for Women (UNIFEM), the United Nations Population Fund (UNFPA) and other UN agencies.

Country Visits and Regional Consultation
In order to ground the recommendations of the Task Force in country realities, working group members, joined by colleagues from UNAIDS, the World Health Organisation (WHO), UNIFEM and the Southern Africa AIDS Information Dissemination Service (SAFAIDS), visited each Task Force country to conduct rapid assessments of the situation and of existing initiatives and actions on gender and HIV/AIDS, and to gather concrete suggestions for action. Country visits were followed by a regional consultation of Task Force members, hosted by Ms. Bellamy, to review what was learnt from the rapid assessments and reach consensus on the way forward.

Global Coalition on Women and AIDS
During the same period, UNAIDS set up a "Global Coalition on Women and AIDS", which seeks to build global and national advocacy to highlight the effects of HIV/AIDS on women and girls and stimulate concrete, effective action. The Task Force is one of a number of regional initiatives under the umbrella of the global coalition. It complements and informs the work of the Global Coalition, focusing on the same issues, but with the particular aim of catalysing urgent action in the sub-region of southern Africa.

MOVING FORWARD
This report and its recommendations are rooted in the experiences and insights of people grappling with these challenges on the ground, supplemented by information from existing literature and discussions with individuals working on human rights, gender and development, and HIV/AIDS within and beyond the sub-region.

In most countries the visits have already catalysed increased action on Task Force issues. It is hoped that the recommendations and substance of this report continue to inspire accelerated action.

EXECUTIVE SUMMARY

"I don't want to die before I'm 110 with great grandchildren. I don't want to die before I turn 25. I refuse to sit down and watch my generation fall to pieces. I am going to make a difference…will you?"
Rumbidzai Grace Mushangi, 15, Zimbabwe[4]

If we can stop the spread of HIV among women and girls in southern Africa, we can turn the epidemic around. While HIV prevalence is high among all sexually active women, *girls and young women* are particularly affected – the vast majority of young people aged 15-24 living with HIV/AIDS in southern Africa are female. Even more worrying, data shows that many young women are being infected almost as soon as they start having sex.[5]

The findings of the United Nations Secretary General's Task Force on Women, Girls and HIV/AIDS in Southern Africa show that gender inequality fuels HIV infection because many women and girls cannot negotiate safer sex or turn down unwanted sex. The findings also demonstrate that HIV/AIDS deepens and exacerbates women's poverty and inequality because it requires them to do more domestic labour as they care for the sick, the dying and the orphaned.

Although the problems are complex, the Task Force has identified key actions in relation to its six focus issues, which can make an immediate difference:

1. Prevention among Girls and Young Women
We must collapse the bridge of infection between older men and younger women and girls.
Many girls have sexual partners who are five to ten years older than them, and these men are more likely to be infected than boys and younger men. Relationships with older men are also more likely to be premised on unequal power relations, leaving girls vulnerable to abuse and exploitation.

2. Girls' Education
We must protect female enrolment figures – AIDS may be taking girls out of school.
Although gender parity has largely been achieved in educational enrolment in southern Africa, we need more information on the impact of the epidemic on the education of girls, particularly orphans.

3. Violence against Women and Girls
We must protect girls and women from the direct and long-term risks of HIV infection as a result of violence
Girls and women who have been sexually assaulted are at increased risk of HIV infection, through direct transmission and because of the long-term effects of sexual violence on risk-taking behaviour

4. Property and Inheritance Rights
We must protect the rights of women and girls to own and inherit land
In Task Force countries there are but a handful of small initiatives by determined organisations that provide women and girls with legal education and advice or assistance to prevent dispossession or restore taken property.

5. Women and Girls as Care Givers
We must put in place a Volunteer Charter articulating the rights and responsibilities of women and men who provide care and support to the sick and orphaned.
Communities, families, governments and development partners cannot continue to rely on 'women's resilience' to provide safety nets for the sick and orphaned.

6. Access to Care and Treatment for Women and Girls
We must address gender norms, violence, stigma and discrimination as potential barriers to women's access to care and treatment.

Although women may have greater access than men to anti-retroviral treatment through public health systems, they may miss out on treatment opportunities because of fear that their partners will discover their HIV status.

Gaps in the Response

The report highlights a number of important gaps in the response by governments, international agencies and civil society organisations identified by the Task Force:

1. Many people know what the gender-based challenges facing women and girls are. However, the complexity of gender relations means that many find it difficult to focus on what exactly to do.

2. Although girls and women represent the bulk of new infections, budgets, programmes, policies and human resource commitments do not reflect this. Many interventions continue to be aimed at an imaginary boy or man or a fictional gender-neutral public.

3. Even organisations that are explicitly trying to address the problems of women and girls find it difficult to deal with the root causes of gender inequality. Because changes in gender relations occur slowly, not enough funding or attention is given to programmes that try to address the deeper connections between gender and HIV/AIDS.

Strategies that Work

After twenty years of HIV/AIDS programming, and thirty years of gender and development programming we know that applying the following approaches can yield success:

- Challenging the social norms and values that contribute to the lower social status of women and girls and condone violence against them, e.g. through dramas and community-based educational initiatives;

- Increasing the self-confidence and self-esteem of girls, e.g. through life-skills and other school-based programmes in which they are full participants;

- Strengthening the legal and policy frameworks that support women's rights to economic independence (including the right to own and inherit land and property) e.g. by restructuring justice systems, enacting laws and training NGOs to popularise these laws;

- Ensuring access to health services and education, in particular life skills and sexuality education for both boys and girls, e.g. by training health workers and teachers on gender, and re-orienting health and education systems so that they are flexible, participatory and community-centred rather than bureaucratic and hierarchical; and

- Empowering women and girls economically, e.g by providing them with access to credit, and business, entrepreneurship and marketing skills.

Strengthening the Response

There are actions that can be taken today, which will make a significant difference. In order to expand the capacities of communities and of those working on HIV/AIDS programmes to do what is necessary to ensure the fulfilment of the rights of women and girls, the following actions are necessary:

- We must expand the pool of gender experts. Despite the fact that many gender frameworks have been developed, not enough people know how to 'do gender' – in other words, how to conduct a thorough gender analysis of the situation and design responses tailored to the different requirements of men, women, boys and girls. There is an urgent need to make the language of gender more practical and accessible to people at community and programme levels.

- We must address the fears and resistance that surround gender. Some women's groups have argued that there has been little progress towards gender equality in some spheres because an honest analysis of power relations provokes discomfort or even active resistance on the part of some men. As a result, those who occupy decision-making positions in donor agencies, community-based organisations, households, governments and NGOs do not prioritise initiatives that seek to challenge the status quo.

- We must support and strengthen local women's movements and organisations. Partnerships between governments, women's organisations and community-based organisations are crucial.

- We must increase public awareness and debate about the relationship between gender inequality and HIV/AIDS.

- We must address the causes of gender inequality, not only the consequences.

In the weeks, months and years following this report, we must work with girls and women to thoroughly analyse their situation using a human rights- and gender-based approach. Together, we must devise strategies that fight HIV/AIDS and simultaneously address gender inequality. We must take this task seriously. To ensure success we must redirect existing resources and mobilise significant additional funds. And we must make sure these resources get to where they are most needed, to the women and the girls in the cities, towns and villages of southern Africa.

Gupta/Tallis Gender & HIV/AIDS Framework (See Annex 1)

Five types of HIV programmes:

Stereotypical – The programmes promote images of men as forceful and powerful while women are portrayed as "powerless victims."

Gender-neutral – These programmes do not distinguish between the different needs of women and men and are aimed at the general population. While they are not trying to deliberately exclude women, they often are based on research and messages that have been tested on men, or work better for men. According to Tallis the bulk of AIDS programmes fall into this category.

Gender-sensitive – These programmes respond to the different needs and constraints of individuals based on their gender and sexuality. Some current AIDS programmes operate at this level, where women's practical needs are identified and attempts are made to meet those needs through service delivery (e.g. female condoms). Some of these programmes work with men, often helping them to consider how they can make better, safer decisions to protect themselves, their partners and their children. However, these programmes operate within the paradigm of men's roles as providers, decision-makers and heads of households.

Empowering – These programmes support women to take the necessary actions at personal, as well as group/collective/''community' levels. Yet without shifting the laws and community values that often make women's lives harder, empowerment is not sustainable.

Transformational – The objective of these programmes is to transform gender relations between women and men so that they are equitable. They focus on radical change at the personal, relationship (including the redefinition of heterosexual relations), community and societal levels. Transformational programmes address the systems, mechanisms, policies and practices that are needed to support such genuine change and include changing laws such as those governing property and inheritance, domestic violence and marital rape, changing the attitudes of men and women about male and female behaviour, and empowering women to access credit, employment and other opportunities for broader development.

I. CONTEXT

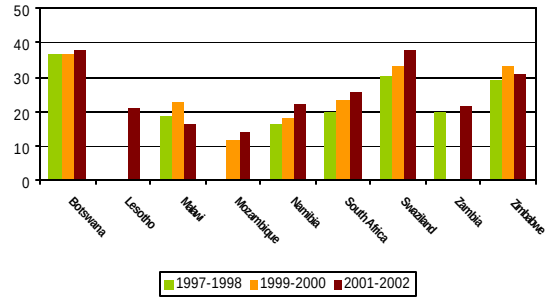
"The railway line that goes through this town links Mozambique with South Africa and Zimbabwe. During the war in the 1980s, the trains were guarded by soldiers from those countries. There were shortages of food in those days and the relief supplies would come into Mozambique on those trains. Many of the women around here were starving, and they would sell their bodies just to eat. The problems started then." - Doctor, Gaza, Mozambique[6]

HIV/AIDS in Southern Africa

As the graphs below show, southern Africa is, by all measures, the sub-region of sub-Saharan Africa most affected by HIV/AIDS.[7] In fact it is the epicentre of the global HIV/AIDS epidemic. Overall, it appears that the HIV epidemic in southern Africa is stabilizing at very high levels of prevalence. In 2002, more than 20 per cent of pregnant women tested were infected with HIV, with several countries reporting the HIV prevalence in antenatal care clinics to be greater than 25 per cent.[8]

HIV levels among women in Southern African countries remain high

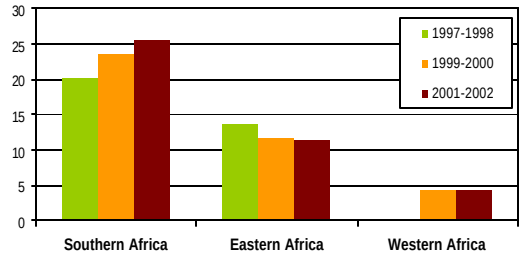
Trends in HIV prevalence among women attending antenatal care clinics in Southern Africa, 1997-2002



Source HIV/AIDS Epidemiological Surveillance Update for the WHO African Region 2002. World Health Organization, Regional Office for Africa, Harare, Zimbabwe, September 2003.

HIV levels highest among women in Southern Africa

Trends in country median HIV prevalence among women attending antenatal care clinics in three sub-regions, data from the same clinics, 1997-2002



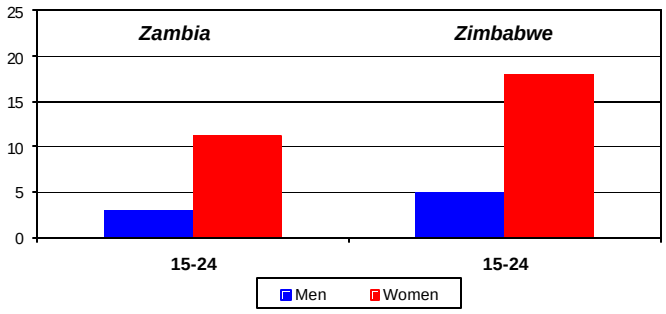
Source HIV/AIDS Epidemiological Surveillance Update for the WHO African Region 2002. World Health Organization, Regional Office for Africa, Harare, Zimbabwe, September 2003.

HIV/AIDS, Women and Girls in Southern Africa

Sub-Saharan Africa is also the only region in the world where more women than men are infected with HIV[9] - more than half of people living with HIV/AIDS in this region are women.[10] Adult women in sub-Saharan Africa are 1.3 times more likely to be infected with HIV than their male counterparts.[11] The impact on girls and young women aged 15-24 is even more disproportionate - they are 2.5 times more likely to be infected than their male age mates are.[12] In southern Africa this gap is larger yet - in Zambia and Zimbabwe for example, girls and young women make up nearly 80 per cent of all young people (15 – 24) living with HIV, as the graph below shows.

Nearly 80% of all young people (age 15-24 years) who are infected with HIV in Zambia and Zimbabwe are women

HIV prevalence among young men and women aged 15-24 years in national population-based surveys, Zambia and Zimbabwe, 2001-2002



Source: HIV/AIDS Epidemiological Surveillance Update for the WHO African Region 2002. World Health Organization, Regional Office for Africa, Harare, Zimbabwe, September 2003.

These figures prompt one to ask, "Why are women and girls in southern Africa so disproportionately impacted?" The answers are to be found not only the pervasive gender inequality that characterises sub-Saharan Africa as a whole. They also lie in a number of features that are unique to Southern Africa, which contribute to the increased vulnerability of women and girls. These contextual factors – related to gender norms, poverty, inequality, mobility, and violence – have too long been ignored, allowing HIV/AIDS to gain a tenacious foothold in the sub-region.

Social Norms and Values

In the last thirty years many programmes aimed at addressing gender inequality have been successful. In southern Africa, there are more girls in primary school than boys, and in most countries, women's participation in political life has also increased.[13]

Despite this trend, the human rights of girls and women are not being fulfilled. In some Task Force countries married women are legal minors, meaning they cannot own or inherit immovable property, and need permission from a male family member to make important financial decisions. This is but one visible manifestation of the ingrained social and cultural norms that continue to assign women throughout the sub-region lower social and economic status than men, placing limits on their mobility and ability to make decisions, and leaving them vulnerable to poverty, exploitation, violence – and ultimately HIV infection. This situation endures despite the fact that equal rights for women and girls have been enshrined in international and regional instruments for decades.

Poverty, Economic Inequality, Gender and HIV/AIDS

Poverty remains a critical challenge throughout much of southern Africa. The food insecurity that has gripped the region in recent years is deepening this poverty and compromising the ability of communities to withstand further shocks, including the impact of HIV/AIDS. Southern Africa has the highest average proportion of female-headed households in sub-Saharan Africa. Thirty four per cent of households with children in southern Africa are female-headed, as compared to 18 per cent in West and Central Africa

and 21per cent in East Africa. The proportion is particularly high in Botswana (52 per cent), Namibia (47 per cent) and South Africa (46 per cent).[14]

Already the poorest, these women are expected to ensure that their families cope – potentially forcing them to exchange sex for food or commodities.[15] Girls are particularly vulnerable to exploitation and abuse in the face of poverty.

Poverty, gender inequality and HIV/AIDS are linked in a vicious circle. Poverty can lead to risk-taking behaviour, for example when a woman or girl has unprotected sex to ensure she gets (more) money or goods. In turn, HIV/AIDS deepens poverty and gender inequality as it burdens women and girls with care responsibilities, taking them away from productive, income-producing activities.[16]

While poverty is an important factor and is worsening in southern Africa, a defining feature of the sub-region is its pervasive social and economic inequality. The Task Force countries are some of the most economically unequal in the world (as measured by the 'Gini coefficient'), with large gaps between rich and poor. As discussed below, this inequality, coupled with a growing culture of consumerism, provides fertile ground for exploitative transactional, 'survival' and inter-generational sex.

Insecurity, Conflict, Gender and HIV/AIDS

Increased vulnerability and violence against women are common characteristics of situations in which poverty, inequality and HIV/AIDS are exacerbated by insecurity and/or armed conflict. Regardless of the environment in which it is perpetrated, violence against women is closely linked to insecurity, whether economic, physical or food-related. Whether in a situation of drought leading to hunger or in a situation of war leading to the search for protection, the vulnerability of women and the risk of violence and increased HIV transmission is high.

A number of southern African countries host significant populations of refugees, the majority of them women and children, who have been deprived of the community structures and support systems that protected them in the past. Food insecurity, hunger and unequal distribution of material goods put refugee girls and women at risk of sexual violence, exploitation and abuse, including coercion into transactional sex for survival. In addition, refugee women and girls often find themselves as new heads of households, responsible for providing for their families in addition to caring for children. This double-edged sword of high HIV infection rates and conflict places women and girls in a uniquely vulnerable position. Yet most national HIV/AIDS strategic plans do not include specific programmes for refugees, let alone programmes to address the particular needs of refugee women and girls.

Gender and Migration

Much of southern Africa is also characterised by a migrant labour system that has separated many women from their partners and created an economic dependence on men which is significantly more marked in this region than in other parts of sub-Saharan Africa, where market trading and other forms of enterprise are more common. The system historically forced mineworkers and other migrant labourers to leave their families behind and live in single sex hostels for long periods of time.

Social alienation and missed educational opportunities are hallmarks of the forms of migration that are peculiar to southern Africa. Those who have moved in search of employment, either as miners or as domestic labourers – the most common forms of employment among women and men in the region –lack the social systems and networks to ensure safer sexual behaviour. Female partners of migrant men may remain monogamous, but become infected when their partners return home for visits. Studies have shown that these wives often feel they can't ask their returning (and bread-winning) husbands to use condoms. On the other hand, new data from South Africa shows that it is often the female partner rather than the HIV-negative migrant worker (usually a miner) who is HIV-infected (in 29 per cent of these sero-discordant couples it is the woman who is infected).[17] The reasons for this are not clear, but (aside from loneliness) may include women resorting to survival sex if the men don't send home enough money.

Since the end of apartheid, millions of people from surrounding countries have crossed South Africa's borders to trade, shop, seek asylum, and gain access to essential services such as health care. Informal cross border trading has mushroomed and many of the traders are women. Furthermore, as the mines have shed jobs, women from neighbouring countries have begun to seek work in South Africa, either as farm labourers, domestic workers or factory hands.[18] These female migrant workers may face abuse and exploitation.

Women are much more mobile than they have ever been before, although they tend to migrate to places that are closer to home, and they return home more frequently. This high degree of mobility and migration, facilitated by the highly developed road networks that span southern Africa, has undermined family cohesion and fuelled transient, casual sexual relations. HIV prevention programmes must do more to address the social systems that have been established around the migrant labour system and acknowledge how these are changing and altering women's vulnerabilities and strengths.[19]

What about men and boys?

"The time is ripe to start seeing men not as some kind of problem, but as part of the solution. All over the world, men tend to have more sex partners than women, including more extramarital partners. That increases the risk they'll contract HIV and pass it on. The risk is also compounded by the secrecy, stigma and shame surrounding HIV, which may prevent people from admitting they have become infected. Infected men may not seek medical help, even if they know they are HIV-positive... too often, it is seen as unmanly to worry about avoiding drug-related risks, or to bother with condoms."

- Peter Piot, Executive Director, Joint United Nations Programme on HIV/AIDS, 2000[20]

Throughout the country visits the same questions were raised repeatedly – "Why the focus on women and girls? What about men and boys?" The answers are simple: women and girls are vastly more impacted by HIV/AIDS in this sub-region than are men and boys. Given the urgency of the situation, and the relative neglect of women and girls in the research and programming agendas of many agencies, the Task Force has consciously chosen to focus on girls and young women.

However, the epidemic in this region feeds off the unequal power relations between men and women. For this reason the Task Force looks at the situation of women and girls through a gender lens (see Annex 1 for the conceptual framework used by the Task Force). This requires looking at how women and girls are differently impacted than men and boys and how socially constructed gender roles and relations affect their ability to prevent HIV infection and cope with its impact.

Bringing men and boys on board as partners will benefit not only girls and women, but also boys and men. The burden of gender inequality weighs heavily on men's shoulders. Gender norms often encourage them to take sexual risks to prove themselves to be 'real men', and discourage them from using health services or seeking help with emotional problems.[21] Transformed gender relations will enable them to adopt behaviours that reduce their own risk of transmission.

Intergenerational Sex and Sexual Violence

As discussed elsewhere in this report, southern Africa is characterised by high levels of inter-generational sex and sexual violence, both key drivers of the epidemic in the sub-region.

Marginalised Women and Girls

It is no easy task to find the most vulnerable women and girls, as they tend not to be organised. In South Africa, for example, the second largest employment sector for women is domestic work. and this pattern probably applies across the region. The Perinatal Research Unit at Baragwanath Hospital in Soweto is embarking upon a study that seeks to understand the sexual health needs of domestic workers. An important element of the research will be to examine issues of social alienation and loneliness that might lead to vulnerability to HIV/AIDS. Identifying marginalised women such as domestic workers is critical in developing innovative ways of addressing women's needs and realities in the context of HIV/AIDS.

By working through community-based organisations (CBOs), support groups, and service providers who do not traditionally provide support in the health sector, but are involved with broader development work, governments and NGOs can identify and reach the most marginalised of women and girls within communities. Thinking differently about the needs of women, and finding ways to help women organise themselves, will be essential as programmes begin to grapple with how best to meet women's long and short-term needs.

MOVING FORWARD

The Task Force suggests that gender must be used as a primary tool of analysis and hopes that by highlighting the demands that AIDS places on women and girls at the household and community level, and illustrating the higher infection rates among them, it can catalyse the development of more gender-transformatory approaches and provision of increased funding to addressing the challenges faced by women and girls. Such approaches must involve girls and women as central actors in their own development.

Programmatic interventions aimed at improving the livelihoods of households affected by the humanitarian crisis in southern Africa must do far more to respond to the changing nature of households and the increasing burden on women and girls. Vulnerability analyses done at regional and country levels must include gender-disaggregated data and more rigorous gender analyses. Such gender-based analyses should also serve to shift macro-economic policies to ensure greater economic empowerment of women.

We cannot wait for the social and economic context to change before taking action. The remainder of this report contains concrete lines of action proposed by the Task Force to fulfil the rights of women and girls, while tackling the longer term challenges that frame the HIV/AIDS epidemic in southern Africa.

II. LEADERSHIP

"…you just go to do what you can -- sweep, draw water, bring firewood. Sometimes the patient needs aspirin, but you don't have money for that."
- Emilia Mwange, a woman from rural Zambia who organizes home care for people with AIDS and other diseases in her village.[22]

The HIV/AIDS epidemic has highlighted the fact that leaders come from all walks of life. Like the woman quoted above, leaders are those who insist on doing something where others might give up.

Community-based organisations (CBOs), many of them reliant on the (unpaid) efforts of women, have taken a leadership role in providing for the basic needs of women and men in AIDS-affected households. Many of these grassroots responses have a clear focus on alleviating poverty.

Associations and networks of people living with HIV/AIDS have played a significant role in the response. At first primarily concerned with protecting their members from the effects of stigma and discrimination and lobbying for access to treatment, such organisations are increasingly seen as partners in the development of HIV/AIDS policies and laws more broadly. As with CBOs, men are more visible in the leadership structures, although women tend to outnumber them as activists in support groups and other community-based activities. Women must be supported to participate at all levels of leadership within these organisations, so that they can be in a position to shape programmes and policies.

Women's advocacy organisations have been quick to point out the links between gender inequality and the HIV/AIDS epidemic. By conducting research that demonstrates the ways in which HIV/AIDS is affecting women's abilities to cope with poverty and other social concerns, these groups have helped to shape a number of national-level laws and policies in recent years.

Key International and Regional Commitments on Gender and HIV/AIDS

- Millennium Development Goals (2000)
- Declaration of Commitment of the United Nations General Assembly Special Session on HIV/AIDS (2001)
- Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases (2001)
- Convention on the Elimination of All forms of Discrimination Against Women (1979)
- Convention on the Rights of the Child (1989)
- Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (2003)
- Gender and Development Declaration by Heads of State of SADC (1999)
- SADC HIV/AIDS Strategic Framework and Plan of Action (2003-2007)
- The Maseru Declaration on the Fight against HIV/AIDS in the SADC Region (2003)
- High Level Committee on Programmes, policy document on "Organizing the UN Response to the Triple Threat of Food Insecurity, Weakened Capacity for Governance and AIDS, Particularly in Southern and Eastern Africa" (2003)
- Platform for Action, Fourth World Conference on Women (1995)
- Programme of Action, International Conference on Population and Development (1994)

Government departments have sped up policy processes and senior leaders from Task Force countries have made statements affirming the rights of women and highlighting the impact of HIV/AIDS on them. Increasingly government law commissions are reviewing and revising laws that discriminate on the basis of gender.

Governments have also signed on to a range of international agreements that place clear obligations on governments to respect, protect and fulfil the rights of women and girls. These obligations have been reinforced by commitments made by governments in a range of international and regional forums (see box above), including during the UN General Assembly Special Session on HIV/AIDS.

The media were often criticised during the country visits as prone to sensationalism and perpetuation of stereotypes, particularly in relation to sex, HIV/AIDS and violence. They can, however, play an immensely positive role. Not only can the media promote images of positive, respectful relationships between men and women, but they can also provide a space where a range of voices is heard and discrimination is challenged. This can arguably have far more effect than more conventional communication messages. More support should be given to the interactive, educational function of media, particularly community and youth media, rather than merely its information dissemination function. The role of the media in challenging government policies and campaigns is also important.[23]

Making the Links

Despite these advances, government officials, women's leaders, and CBOs consulted during country visits continued to lament the fact that a significant gap remains between these declarations and policy commitments, and the reality on the ground.

In particular, many programmes struggle to address the gender dynamics of the epidemic. Given the pressures grassroots organisations face to meet the basic needs of communities, it is understandable that making the linkages with notions of gender inequality may seem too abstract. Conversely, while larger women's groups may focus on gender inequality, they often lack the capacity to attend to both the policy and research arena and the gender needs of women in villages.

As Stephen Lewis and James Morris point out in their mission report, which gave rise to this Task Force, gender – because it is crosscutting – seems to be everyone's problem, but no one's responsibility.[24] This is particularly true in government agencies. Although ministries are aware that something should be done, none see themselves as tasked with the ultimate job of ensuring that gender inequality is indeed tackled in a systematic programmatic manner.

At all levels, a strengthened response will require a concerted effort to ensure that interventions address the basic needs of women *and* take into consideration the human rights violations and gender inequalities that drive the epidemic.

The institutions that are responsible for coordinating national HIV/AIDS response and for mainstreaming gender must be strengthened so that they are better able to support the efforts of government agencies and civil society groups.

National AIDS Councils and National Strategic Plans

Multi-sectoral National AIDS Councils or Commissions, the bodies tasked with coordinating national responses to HIV/AIDS, vary in size and capacity, but in all Task Force countries they will benefit from increased capacity on gender. The Task Force found that many national HIV/AIDS policies, and/or the strategic plans that guide their work, barely acknowledge the impact of HIV on women. Where gender is mentioned in these documents, it usually features in the analysis of the problem (as a 'cross-cutting' issue), but disappears in subsequent sections that detail programme responses and budgetary allocations.

Gender Ministries

A number of Task Force countries have Ministries of Gender or of Women's Affairs established with a mandate to mainstream gender in all sectors. This often includes providing guidance, training and

research in support of these line ministries with the ultimate accountability for implementation. They also act as gender watchdogs, reviewing and monitoring legislation, policies, programmes and budget expenditures of line ministries.

However, in some cases, the roles are blurred and implementation roles are assigned to, or taken up by these bodies, which do not have the resources or infrastructure to fulfil them. In one Task Force country, for example, the gender ministry – with few resources and almost no staff outside the capital city – was , involved in the distribution of female condoms, a function now being taken over by the Ministry of Health, which has the required capacity and infrastructure. Assigning 'women's issues' to 'special' departments has the effect of marginalizing them, and puts the responsibility for protecting half of the country's citizens in the wrong place. Gender must be integrated into the daily work of governments and NGOs.

On the other hand, because their function is mainstreaming rather than implementation gender ministries are often not given the power and resources to fulfil their role properly, leaving them ineffectual. These ministries are often over-burdened and require more funding to cover even the basic support that they are supposed to provide.

A particular problem highlighted during country visits was lack of communication between the bodies tasked with coordinating the gender response and those coordinating the HIV/AIDS response. In one country, a consultation during the Task Force visit brought key people from the gender ministry and National AIDS Council secretariat together for the first time. Collaboration between these two mainstreaming bodies must be improved in all Task Force countries.

The Southern African Development Community (SADC)

Gender must be thoroughly integrated into the implementation of the SADC HIV/AIDS strategic framework. The SADC secretariat can ensure that the recommendations of the Task Force are given priority attention at national level – for example, by submitting them to member states for endorsement when they meet, and monitoring progress.

Donors and development partners

According to UNAIDS, HIV/AIDS-related spending by governments, international organizations, foundations and NGOs increased nine-fold from 1996 to 2002.[25] Despite this, country visits revealed a significant resource gap, particularly acute around Task Force issues. Moreover, the complicated procedures and reporting requirements of various donors are often not coordinated, and money rarely trickles down to those levels where it will have the most effective impact on gender transformation.

The United Nations system

The UN system has a critical role to play in ensuring a coordinated and urgent response to the crisis facing women and girls in southern Africa.

In late 2003 the United Nations Chief Executive Board for Coordination endorsed a report setting out a new way of working for the UN system in southern and eastern Africa, in order to address the triple threat of food insecurity, weakened capacity for governance, and HIV/AIDS.[26] This report (commonly referred to as the 'HLCP paper on the triple threat', after the High Level Committee on Programmes which developed it), sets the UN the task of "changing gears" – reviewing, reorienting and scaling up relevant programmes to ensure that results are achieved.

This policy document commits the UN to intensify its action to simultaneously address short-term needs and long-term challenges, employing the tools at its disposal, directing its moral authority and investing managerial and financial resources to help its partners defeat AIDS. As part of its new way of doing business, the document commits the UN to action to empower women, working through the Task Force.

At *country level* the overall aim of the UN should be "to support in-country capacities - including those of national, local and community governance systems – to mount a multi-sectoral response."[27] In this work,

the UN must ensure that gender and HIV/AIDS, and their linkages, are integrated in the following mechanisms:

- CCA/UNDAF: The basis of UN support for national efforts is the common country assessment (CCA) and UN development assistance framework (UNDAF), developed through dialogue with government and development partners. If the differing impacts of the epidemic on women and men, girls and boys, are thoroughly teased out through the CCA, there will be a much stronger basis for integrating gender into planning and programme implementation. It may be necessary to review CCAs and/or UNDAFs mid-stream to this end.

- Poverty Reduction Strategy Papers/Sector-Wide Approaches: The UN has a role in assisting governments in the development of Poverty Reduction Strategy Papers (PRSPs) and Sector Wide Approaches (SWAPs). PRSPs are intended to serve as a framework for domestic policies and external assistance for poverty reduction. They have fostered changes at the national level, including mobilising government commitment. It is widely agreed that HIV/AIDS should be prominent in the PRSPs of African countries in light of the threat the epidemic poses to poverty reduction efforts. UN agencies can play a greater role in assessing how the PRSP process has enhanced the implementation of HIV/AIDS policies relevant to women and girls.

- UN Resident Coordinator System & UN Theme Group: In order to ensure that gender is indeed integrated into the CCAs and UNDAFs, and that Task Force recommendations are implemented, UN Resident Coordinator's offices and UN Theme Groups on HIV/AIDS may require additional capacity and gender expertise. In some Task Force countries the Theme Groups on HIV/AIDS and Gender have merged or meet jointly on a regular basis, or were brought together to coordinate the Task Force process. Such close liaison should be encouraged in other countries. Urgent action is required where Theme Groups on Gender don't exist or are not functioning effectively.

In addition to working through these mechanisms, the UN can play a variety of important roles in prioritising a focus on the gendered nature of the epidemic in southern Africa. These include:

- Convening: The UN plays a unique role in the development community by virtue of its ties to government, civil society and donors. During the Task Force country visits the UN showed its ability to bring together a diverse group of stakeholders, from government, NGOs, CBOs, the private sector, academic institutions, associations of people living with HIV/AIDS and the donor community. In some cases it was the first time some of the key players had sat around a table, at least to discuss the impact of HIV/AIDS on women and girls. In following up on the Task Force recommendations, the UN should continue and expand this role, for example by creating country-level task forces on women, girls and HIV/AIDS. The ultimate aim should be to support programming at grassroots level.

- Resource mobilization: The UN has a key role to play in mobilizing resources for an intensified response on women, girls and HIV/AIDS, ensuring greater coordination of donor requirements and processes, and finding innovative ways to get these resources down to community level. The UN must strongly advocate with donors to ensure that their funding priorities are driven by the need to mitigate the effect of gender inequality on the epidemic in the region. The gender dynamics of the epidemic must also inform the technical assistance that the UN routinely provides to the development of proposals to donors and to such funding mechanisms as the Global Fund to fight AIDS, TB and Malaria and UNAIDS Programme Acceleration Funds (PAF).

- Coordination: The UN should help ensure that all development partners work together under government leadership on gender and HIV/AIDS by supporting the integration of gender into ONE national AIDS coordinating body, ONE national AIDS strategy and ONE national monitoring and reporting system.

- Capacity Building and Technical Support: The UN must develop the capacity of its partners in gender analysis and gender-transformative programming, to ensure that gender does not remain confined to the pages of policy documents but rather is mainstreamed in the implementation of programmes. The

UN should consider setting up inter-agency working groups on Task Force issues to advise and provide technical assistance to concerned government institutions, facilitate inter-departmental collaboration, and support government on how to proceed with reforms, including the elaboration of necessary training manuals and the sharing of successful models from elsewhere.

- Advocacy: In each Task Force country, the UN should develop a focused advocacy plan, based on the findings of the Task Force and tailored to country realities. Task Force members could have much to contribute to this process. Advocacy must focus on showing the reality of the HIV epidemic in southern Africa through the eyes of women and girls.

- Research: The UN should provide support to ensure that the research needs identified by the Task Force are met.

- Reporting and monitoring: In fulfilling its role of monitoring the fulfilment of international and regional commitments by governments, the UN must again keep its focus on the gendered nature of the epidemic and the commitments made by governments to protect and promote the human rights of women and girls. UN country teams must include updates on progress in implementing Task Force recommendations in their own annual reports.

- Collaboration with civil society: In all of the above, the UN must, as the HLCP paper states, "focus more of its capacity-building technical resources and financial resources on civil society and community organisations." In particular the UN should ensure greater collaboration with and support for women's organizations, particularly those working at grassroots level, and associations of people living with HIV/AIDS.

In order to fulfil all these functions, UN country teams will require support at the regional level. In particular, regional UN offices must immediately begin to mobilise resources for countries, support the development of advocacy strategies, and gather and disseminate strategic information on the trends of the epidemic in the sub-region. The UN must advocate for intensified action on gender and HIV/AIDS with donors, regional inter-governmental bodies (in particular SADC), and regional or international NGOs, and monitor progress in implementing Task Force recommendations. As the actions set out in the HLCP paper are implemented, the UN must ensure that gender is integrated throughout.

An example: UN system collaboration on HIV/AIDS and gender in Mozambique
The UN system in Mozambique has put in place strong collaborative mechanisms between the Theme Group on HIV/AIDS and the Thematic Working Group on Gender. The two theme groups worked with the Ministry of Gender to coordinate the Task Force country visit. Based on lessons learnt from their ongoing collaboration, Heads of Agencies recently decided to pool resources to employ a full-time gender officer in the Resident Coordinator's office.

RECOMMENDATIONS

Key Recommendation:
The Task Force recommends that donors and development partners::
- ❑ By December 2004, create an HIV/AIDS small-grants fund in each of the nine countries to support community initiatives on gender.

Further Recommendations:
The Task Force recommends that Governments:
- ❑ By December 2004, with technical guidance and support from the United Nations and SADC, complete gender & HIV/AIDS audits in each country assessing (to the extent feasible):
    - the proportion of resources for the HIV/AIDS response that is allocated to issues related to women, girls and gender;
    - the number and capacity of women's organizations active in the HIV/AIDS response; and

- gaps in the response on gender and HIV/AIDS.

The results of these audits should be used to advocate for accelerated action.

- By March 2005, ensure that gender is integrated into all National AIDS Strategic Plans and the implementation of programmes funded by National AIDS Councils;

- By August 2004, formally request that key UN and donor agencies begin to harmonise and rationalise funding processes — e.g. proposals, procedures, disbursement of funds, and reporting requirements — to ensure more efficient channelling of funds to where they are most needed;

- Ensure that the opportunities provided by poverty reduction strategy papers (PRSPs) and sector wide approaches (SWAPS) are seized to intensify HIV/AIDS efforts for women and girls;

- By March 2005, increase financial assistance to coordinating bodies responsible for mainstreaming gender in the HIV/AIDS response by at least 25 per cent from current levels.

The Task Force recommends that donors and development partners:

- By March 2005, increase financial assistance to women's organisations addressing HIV/AIDS by at least 25 per cent from current levels;

- By March 2005, increase financial assistance for men's organizations working to transform men's relationships with women in order to address violence and HIV/AIDS by 25 per cent from current levels.

The Task Force recommends that the United Nations:

- By September 2004 have in place a regional resource mobilisation strategy for a series of campaigns that will address gender and HIV/AIDS.

The Task Force recommends that governments, civil society and development partners collaborate to:

- By December 2004, support or create structures within associations of people living with HIV/AIDS or affiliated with them, which provide an environment conducive to the development and growth of leadership by women living with HIV/AIDS. Furthermore, support the strengthening of regional networks of HIV-positive women to achieve similar aims at a regional level.

- By March 2005, implement a policy to ensure that all funding proposals from NGOs and CBOs are responsive to gender issues at the community level.

III. FOCUS ISSUES

1. Prevention among girls and young women

"They all think that girls are supposed to be their doormat. I think boys must be taught to look at girls as people."
- Fifteen-year old girl, South Africa[28]

All young people are vulnerable to HIV/AIDS but as we have seen girls are particularly vulnerable. Roughly two-thirds of young people aged 15-24 living with HIV/AIDS in Sub-Saharan Africa are female and, as we have seen this proportion is even higher – as much as 80 per cent - in some countries.

Women are biologically more vulnerable to HIV infection than men, as they have a greater surface area of mucous membranes exposed to the virus during sexual intercourse. Girls are particularly vulnerable, as their membranes have not yet developed fully and are permeated easily (while immature genitalia seem to decrease risk of transmission for men).[29] Girls tend to start having sex regularly earlier than boys, further increasing the risk of transmission.

These biological differences are amplified by deep-rooted gender inequalities and social norms that require women, and particularly girls, to be passive and ignorant about sex, and submissive to the will of men in determining the terms of sexual relationships. Add to this the high levels of coerced or forced sex in the sub-region and you have a recipe for disaster.

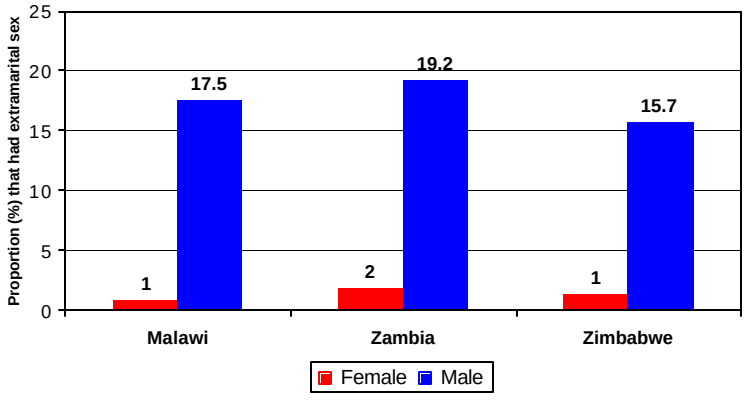
Prevention options for girls
Within this context, the dominant prevention messages in the region - Abstinence, Being Faithful and Condom Use, the so-called ABC of prevention – do not present girls with real options.

A: ABSTINENCE - It is hard for girls to choose to abstain when their communities expect boys and men to initiate sex and girls are not taught how to even broach the subject. Abstinence is impossible when sex is forced or coerced and is not a viable option when women and girls resort to sex for survival.

B: BE FAITHFUL - Social norms dictate that it is acceptable, even encouraged, for men and boys to have a variety of sexual partners. As one male adolescent in Namibia said, "you can get famous if you have a lot of girls."

Men put their wives at risk

Percent currently married women and men who report having had sexual intercourse with someone else than spouse/cohabiting partner in the last 12 months



Source: DHS 1999-2002

Being faithful to one regular partner is not enough to protect girls and young women if that partner is not being faithful to her. Being faithful to a partner who is older, and therefore more likely to be infected (see below) also does not protect. In some settings this message has been found to create the false perception among young people that being faithful to one partner at a time in serial relationships is protective.

"We [men] are to blame because we normally say that you don't need to have the same kind of meat every day, meaning that despite your real girlfriend, you have other multiple girlfriends, somewhere else."
- Participant in a focus group discussion of urban men, Zambia[30]

"I used to have one new girl a week. I would meet them everywhere. And added to them were the girls I knew before. I was never shy about getting girls to sleep with me."
- 39-year-old bus conductor, Swaziland[31]

C: CONDOM USE - As for male condoms, their use is almost always controlled by men, who are often reluctant to use them. As one adolescent girl in Lesotho explained, "some boys say they can't have a sweet wrapped in plastic, because it is nicer and more sensible to have it without the plastic. It is not always easy to tell them to take a walk."[32] It is even more difficult to discuss condoms with an older man. Girls are also more likely to engage in longer term relationships, and condom use tends to be lower in these than in casual relationships.[33] Although female condoms offer protection to increasing numbers of women, they may also require women to negotiate with their partners, are more expensive than male condoms, and are still not widely available or socially acceptable.

Many women will only be able to have safer sex when a fully woman-controlled prevention method becomes available. Microbicides offer a ray of hope, and a number of Task Force countries are currently involved in trials. But microbicides (if and when they become available) will find their main use in situations where women need to hide their attempts to control their reproductive health and will not address the root causes of gender inequality.

It is little wonder that, throughout the country visits, person after person lamented the fact that HIV/AIDS awareness has not seemed to result in real knowledge, behaviour change or lower infection rates. From the country visits and regional consultation, it is clear that in this sub-region there are three key factors contributing to the greater vulnerability of women and girls to HIV infection, each of which must be addressed:

- The culture of silence surrounding sexuality;
- Exploitative transactional and intergenerational sex
- Violence within relationships with boys and men (discussed elsewhere in this report)

The Culture of Silence

"If you as a woman want to talk about sex to your partner, it is rude"
- Young rural woman, Namibia[34]

The word "taboo" echoed throughout the country visits. Parents, family members and teachers are either too embarrassed to talk to children about sex or feel that it will encourage them to become sexually active, while in fact the opposite has been proven to be true.[35] As a result, real knowledge about HIV transmission and prevention remains disturbingly low for both boys and girls, and few consider themselves to be at risk.

Even where young people are surrounded by HIV prevention messages on billboards, posters, T-shirts and on the radio — to the point where many complain of 'AIDS fatigue' — they are rarely given the space to discuss broader issues of sex and sexuality. Many do not know how their bodies work, and are in the dark about matters related to sex and reproduction. Few campaigns try to attract young people to reproductive health services, or to provide separate messages tailored to the specific needs of young women and young men and different age groups.

Symptomatic of sexual double standards and stereotypes, the taboo is even stronger for girls, A UNICEF study on gender, sexuality and HIV/AIDS in education[36], which included interviews with boys and girls in a number of countries including Botswana, South Africa, Zambia and Zimbabwe, found that,

> "In every country, the young interviewees made a distinction between 'good' girls and 'bad' girls, which centred upon their sexuality. …girls were rebuked for expressing desire, for being seen to be too 'knowledgeable', even for speaking too 'openly' in mixed gender interviews….Both the boys and the girls constructed girls as less sexually active than boys (unless they were 'bad' girls) and as potential objects of boys desires…. Boys as young as six (in Zambia) constructed themselves as initiators of sex, having a more powerful sex drive than girls, as well as buyers of sex, who provided girls with presents and money… - a precursor to the 'sugar daddy' syndrome."

In order to avoid being labelled as 'bad', girls maintain a tight-lipped silence around sexuality, asking few questions and feigning disinterest when often they *are* having sex and need support and guidance.

"When it comes to sex drive, boys are BMWs and girls are Corollas"
- Female secondary school student, Namibia[37]

Exploitative transactional and inter-generational sex

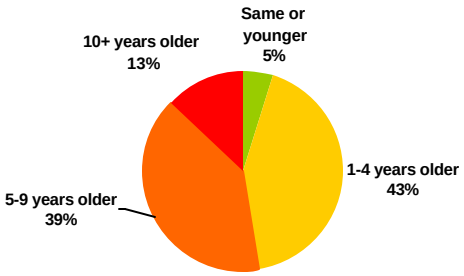
"For most people the gifts are a form of bribery to having sex with them. If one does not agree into sex, she feels that the boy may think that she do not love him, I just wanted his presents."
- Adolescent girl, Botswana[38]

Driven by poverty and the desire for a better life, women and girls from a variety of social backgrounds find themselves having sex in exchange for goods, services, money, transportation, accommodation, or other basic necessities, usually with men they know. Young people in Zimbabwe cynically refer to this as 'food for work'.[39] Research confirms that, in these situations, women are even less likely to be able to protect themselves from HIV infection.[40] The risk of illness and death at some indeterminate future time can seem irrelevant when you are faced with the immediate need to pay school fees that are due, or to put food on the table.[41]

Because of the marked disparity between rich and poor in southern Africa, intergenerational and transactional sex are often about young people's desire for luxury goods in a globalising world in which consumerism is king. Girls and young women are sometimes accused of luring adult men into relationships in order to get status and access to the infamous 'four C's' – cash, cell phone, clothes and a car - mentioned repeatedly during country visits. It is apparent from the abovementioned UNICEF study that "it was girls who were being blamed for pursuing older richer males [and for spreading AIDS] - not the men for attracting the girls."[42]

More than half of all young women have first sex with a man 5 years or older

Age-difference (numbers of years man is older) between female respondent and **first sex partner** for respondents aged 15-29 years, Zimbabwe, 2002



Source: The Zimbabwe Young Adult Survey, 2001-2002.

Sex between younger women and older men is all too common in sub-Saharan Africa. A study in Zimbabwe found that nearly a quarter of women in their twenties are in relationships with men ten years older than themselves.[43] Younger girls are even more likely to have older partners, with an even larger age gap between them. As the chart above illustrates, *more than half* of all young women in a study in Zimbabwe reported that their *first* sexual experience was with a man who was more than five years older than them.

Country visits confirmed that although sexual relations between girls and older men are seen by many as a major problem, the phenomenon is also widely accepted. During the country visit to South Africa, young people revealed that older men often provide much-needed material support to girls' families including for money for school fees, transportation and groceries, reflecting the often intertwined nature of inter-generational and transactional sex. Girls may even face pressure from their parents to engage in relationships for these reasons or in the hopes of eventual marriage.[44]

A study in four African cities demonstrated a strong correlation between high incidence of HIV and the age difference between partners.[45] On average, men become infected with HIV in their mid to late twenties, while women are infected in many cases almost as soon as they start having sex. In a study in Zambia, eighteen per cent of women who said they were virgins a year or less before, were HIV positive. In South Africa, twenty one percent of sexually active girls aged 16 – 18 were infected. In part, this can be explained by the types of relationships in which girls and boys engage. Girls tend to get involved with one long-term partner, with whom they have regular sex, facilitating HIV transmission through repeated exposure if their partner is HIV-positive. Young men are expected to have multiple sexual partners, and as a result tend to have sex less frequently, limiting their potential exposure to the virus. Rates of infection increase among men in their mid to late twenties, when they are more likely to have had regular sexual contact with several women over time.[46]

Older men are accordingly more likely to be infected with HIV than younger men, posing a greater risk of transmission to their younger partners. Men may not know their HIV status and may perceive younger women as more 'pure' and therefore less likely to have HIV and other sexually transmitted diseases. Because they don't perceive risk, they may be reluctant to use condoms.[47] Furthermore, they may feel that giving 'gifts' or money to the girls buys them the right to control the terms of the relationship.

The bottom line is that such relationships, by their very nature, are premised on unequal age, power and economic relations, leaving girls vulnerable to abuse, exploitation and violence. This is of particular concern when girls are under eighteen.

MOVING FORWARD

"As a man, I know men's behavior must change, that we must raise boys differently, to have any hope of eradicating H.I.V. and preventing the emergence of another such scourge…. To change fundamentally how girls and boys learn to relate to each other and how men treat girls and women is slow, painstaking work. But surely our children's lives are worth the effort."
- Pascoal Mocumbi, former Prime Minister, Mozambique[48]

The ABC approach will only present viable options for girls if it is part of a multi-pronged package of interventions that take into consideration the problems girls and women face at the personal, household, family and community levels. These interventions must aim to empower girls and young women by building assertiveness and self-esteem, and through the development of inter-personal communication and leadership skills. Ensuring that girls and young women participate fully in designing and implementing programmes is a prerequisite to success.

Girl Child Network, Zimbabwe
Launched in 1999, the Girl Child Network consists of 150 girls' clubs with over twenty thousand registered and unregistered members. In addition to girls' clubs, the network includes the Chitsotso Girls' Empowerment Village, a 'one stop shop' for rural girls, providing counselling, medical services, shelter from abuse, information, training and a 'women as role models' museum of achievements. Two more Girls' Empowerment Villages are being set up in two other remote parts of the country. The villages provide a mix of good traditional and modern practices and beliefs and are strategically located in the rural areas. Increasing numbers of girls come to these villages to report abuse, receive professional counseling, acquire skills in peer-to-peer counselling and undergo training on starting and running girls' clubs and self-help projects. To date ten rural girls' clubs are running self-help projects benefiting more than two hundred families. The economic benefits girls receive from these projects help to protect them against commercial sex work and HIV/AIDS. Girls are also nurtured and mentored to be future leaders. Two thousand girls have been supported to go back to school, with a number of them even in the most remote rural areas of the country gaining entry into universities. Girl Child Network clubs and programmes are fully owned by the girls and communities, which guarantees sustainability. The Network reports a positive response and support from Zimbabwean men.

Breaking the Silence

Communication strategies and life skills education
There is a need for better controls on the development and use of communication materials, to encourage a stronger emphasis on content rather than on producing T-shirts, caps and rulers. The gap between awareness of HIV/AIDS and the knowledge and skills involved in preventing HIV transmission, is still too large to allow for any wastage of resources.

Communication strategies that focus on creating an environment for interpersonal dialogue and debate, and which provide a voice to women and girls, are more effective than those that focus only on education through messages. Real individual and social change will only come about when people become truly engaged in talking about HIV, gender inequality, sexuality, culture and social norms, and in finding their own solutions to problems.[49]

Schools are ideally placed to facilitate such communication through comprehensive life-skills and sexuality education, particularly considering high enrolment rates in the region. Communities too must play a role but may need support if they are to revive and improve on channels through which information was traditionally provided to young people (e.g from aunts to nieces, or from uncles to nephews). These community elders will require support to ensure that the information they provide is accurate and based on gender equality.

Services
For prevention to be effective, young women and men must also know where to go to seek appropriate health services. It is essential that health workers are trained to handle the questions, concerns and health problems of young people, particularly girls, in non-judgmental ways. Such training must be complemented by measures to relieve the stress on health workers facing increasing workloads and staff shortages. Furthermore, as more young women become infected, the need to develop services aimed at HIV-positive young people becomes more urgent.

Youth programmes that promote gender equality
In the southern African context of high levels of sexual violence and a generalized HIV/AIDS epidemic, programmes must take seriously the gender dynamics between young women and men. Dialogue between young women and young men should be encouraged. This will help ensure that young men are sensitised about respect, and learn to distinguish between appropriate and inappropriate sexual behaviour, and that young women are able to articulate what they want and like, as well as what makes them uncomfortable. This dialogue should serve to facilitate platonic friendships between boys and girls, which is something the UNICEF regional study showed is particularly difficult for them.

Young men often feel rejected by young women because they cannot compete against older men who have disposable income. As one young man in South Africa asked rhetorically during the country visit, "I'm at the desk, she's at the desk, what can I offer her?" Both girls and boys need to be encouraged to contemplate relationships in which boys are not expected to provide economically and take the sexual initiative, as this perpetuates gender inequality and the 'sugar daddy' phenomenon.[50]

Ending Exploitative Relationships

Intergenerational sex is clearly a risk factor for girls, and becomes one for young men and boys who may later marry or become sexually involved with women who were infected early in their sexual lives, as well as for the children these women bear. Research has confirmed that intergenerational sex "has a pivotal role in the persistence of major epidemics…Breaking this link in the pattern of transmission must become a central focus of HIV prevention strategies."[51] As Task Force member Unity Dow said, "we need to collapse the bridge of intergenerational sex between our girls and older men."

The challenge is to change sexual and gender norms through advocacy, gender socialisation of young people and education, so that sex between older men and younger women becomes less accepted. At the same time, social and economic conditions should be created that give choices to girls who may be economically reliant on older men. In all this extreme care must be taken not to place the blame on girls. The onus is on adults to stop engaging in potentially exploitative relationships.

RECOMMENDATIONS

Key Recommendation:
The Task Force recommends that Governments and their partners:

- Create awareness campaigns on the inappropriate, abusive and often illegal character of relationships between older men and teenage girls, promoting the shaming of 'sugar daddies' while protecting the identities of the girls and reaffirming men who do not engage in such practices.

Further Recommendations:
The Task Force recommends that Governments and their partners:

- By June 2005, create or expand budgets for the development and/or improvement of educational materials and socio-economic programmes that address intergenerational and transactional sex.

- By the beginning of the next national budget cycle, increase by at least 50 per cent the communication resources on HIV/AIDS of relevant government departments and NGOs. These resources should be used to develop communication interventions that involve HIV-positive and negative young women and men, as well as communities, in dialogue, based on gender-sensitive and transformatory messages on sexuality and sexual and reproductive health, including HIV prevention.

- By December 2006, establish mechanisms that monitor progress in strengthening health services (and reducing the impact of AIDS on service delivery) so that a minimum of 50 per cent of health services show competence in the provision of appropriate gender-sensitive sexual and reproductive health services to women, girls and adolescents, including the prevention and treatment of sexually transmitted infections (including HIV/AIDS).

- By December 2004, create services and communication interventions focused on positive living, including the need for balanced nutrition, physical exercise, emotional well-being, the prevention of HIV reinfection and the importance of ensuring the sexual and reproductive health and rights of HIV positive women and men.

2. Girls' Education

"Yesterday something happened. There was this girl in class whom some boys were touching and she kept on hitting them with books and telling them to stop and then all of a sudden she started crying, as if something, part of her had been taken away."
- Adolescent girl, Botswana[52]

Education gives girls and women greater control over their lives, and enhanced skills to contribute to their societies and protect their health and well-being. Educated women have fewer, healthier and better educated children.

Recent studies in Zambia and elsewhere have found lower rates of HIV infection among better educated people.[53] Research confirms an association between higher education levels and increased awareness and knowledge of HIV/AIDS, greater knowledge of HIV testing facilities, higher rates of condom use among males and females and better communication on HIV prevention among partners. In Zambia, for example, about 90 per cent of women with higher education report discussing HIV prevention with their partners, as opposed to 50 per cent of women with no education.[54] The mere fact of being in school can be protective, with girls in school showing lower rates of sexual activity than those out of school.[55]

Keeping girls in school

The Millennium Development Goals aim to eliminate all gender disparity in primary and secondary education by 2005 and to give all school-age children access to primary school by 2015. Southern Africa fares better than other sub-regions in sub-Saharan Africa – it has relatively high enrolment rates and gender parity has largely been attained in both primary and secondary enrolment. Indeed in some Task Force countries, the enrolment ratio favours girls.[56]

On the other hand, net enrolment is declining, a shift some researchers have ascribed to HIV/AIDS. Also, because national data currently only reflects secondary enrolment and does not track completion rates, it is difficult to get a true picture of girls' educational attainment. There are myriad reasons why, in all parts of the world, girls tend to drop out of secondary school more than boys. These include pregnancy, early marriage, domestic duties and sexual violence, as well as girls' generally lower social and economic status. Recent and ongoing studies, including in Botswana, Lesotho and Zambia, are confirming anecdotal information suggesting that these inequalities may be increasing as girls are pulled out of school to care for the sick, when they are orphaned, or due to the economic impact of HIV/AIDS on families.[57] In Lesotho, for example recent statistics show that the impact of HIV/AIDS and poverty has led to a 25 per cent decline in girls' enrolment rates during the last decade.[58] However, further research is needed on school completion in Task Force countries, particularly in light of their high rates of orphaning - the evidence clearly shows that orphans are less likely to attend school than non-orphans.[59] We need to get a true picture of the different ways in which the epidemic is affecting enrolment and drop-out rates among girls and boys, including orphans, and design interventions to respond to their particular needs.

We do know that where schooling is not free, fewer children go to school. Children affected by poverty are particularly likely to be denied their right to education where formal or informal fees are imposed. Girls may drop out or end up in relationships with older, wealthier men who help pay for their education. Zambia is one Task Force country that recently took the bold step of abolishing school fees. But abolishing school fees is fraught with challenges - Sub-Saharan Africa faces crippling foreign debt, estimated at more than $200 billion, and plummeting bilateral funding for education, while few countries have shifted significant resources to education from other sectors.[60]

Schools as safe spaces to learn

A key issue in southern Africa is making sure that schools are safe spaces conducive to learning. This is often not the case. A Zimbabwean study on sexual violence in schools indicated that girls experience high levels of violence both from boys and from male teachers. These findings are confirmed by other studies in the region, including in South Africa, Swaziland and Zimbabwe.[61]

In research carried out by UNICEF in Botswana, South Africa, Zambia, Zimbabwe and other countries in sub-Saharan Africa, girls listed sexual harassment, including unwanted touching or sexual comments, as their most pressing problem.[62] According to one girl in Zimbabwe, "[b]oys will stand in the doorway when you want to pass. When you pass, they touch you and laugh at you closely into your face."[63] A fourteen-year-old girl in South Africa told Human Rights Watch of the pervasive nature of such harassment and its impact on learning: "All the touching at school in class, in the corridors, all day everyday bothers me. Boys touch your bum, your breasts. You won't finish your work because they are pestering you the whole time."[64]

Harassment is not confined to fellow students. The UNICEF regional study on gender, sexuality and HIV/AIDS concluded that constructing girls as objects of desire seemed to provide boys and even male teachers with a license to sexually harass and abuse them. Zambian girls in their late teens, for example, spoke about how teachers exploited their power by offering the girls 'leakages' from exam papers in exchange for 'love'. Girls in Zambia and Zimbabwe reported that if they refused sexual advances from teachers they would be ignored in class, punished, given low marks or insulted in front of classmates.[65]

Girls come to school expecting guidance and protection from teachers. This type of harassment impacts not only on their self-esteem and ability to learn, but also increases their vulnerability to HIV infection, since teachers in the region have been significantly affected themselves – a study in Zimbabwe, for example, found that 19 per cent of male teachers were infected with HIV.[66] This is also the very factor that hampers the response. Faced with dwindling numbers of teachers as a result of AIDS and the brain drain to industrialised countries, schools are reluctant to suspend or dismiss teachers who abuse students.

Girls are also reluctant to report abuse and harassment, since they are routinely disbelieved or blamed, and action is rarely taken. As one girl in Botswana said, "…one time a boy kissed me on the cheek and I didn't like it, it felt so wrong and painful, and I thought of reporting but I felt teachers will think that I was joking or I wanted it to happen."[67] A UNICEF-supported study in Swaziland highlighted this silence around issues of abuse and harassment and found that not only students but also teachers and parents were reluctant to speak out, report cases or bring charges.[68]

This silence is compounded by the lack of clear guidelines for reporting cases of sexual violence or harassment. Teachers often have no idea how to assist students who are attacked or abused either at home or in the schoolyard. All of this is complicated by a lack of clear definition of what constitutes abuse or harassment in the context of social norms that facilitate male control over female sexuality.

Learning life skills

Boys and girls need to learn how to make informed decisions, communicate effectively, assert themselves, manage anger and resolve conflict without resorting to violence, and build their self esteem. It is clear from the regional UNICEF study that they need to learn about respectful ways of dealing with each other on a basis of equality. Participatory life skills programmes for boys and girls, both in and out of school, and supported by appropriate training of teachers and peer facilitators, can contribute to reducing violence against women and girls and the risk of HIV transmission.

However, only a few countries recognise this in their policies and strategies. Although there has been increasing effort in southern Africa to develop life-skills curricula for in-school programmes, only four Task Force countries have fully fledged life-skills programmes, while other countries are at varying stages of development. It was apparent from the country visits that even where such programmes exist, many teachers feel ill-equipped to teach life skills and the subject is rarely given high priority. Further, life-skills materials often do not include explicit modules on gender roles and relations, empowerment of girls, masculinities, or gender-based violence, and only a small percentage of out-of-school children are being reached by such programmes.

In addition, teachers themselves tend to perpetuate gender stereotypes in the classroom. As one adolescent girl in Botswana recounted, "…one time the teacher gave back our test papers and said that

girls had performed better than boys, she told the boys she was going to beat them because they were not supposed to be led by girls and went ahead and beat them. I think this is being gender insensitive, telling boys to perform better and yet we are taught about equality yet teachers don't practice it, it is unfair."[69]

MOVING FORWARD

Gender Audit and Girls' Education Movement, Lesotho

A gender audit of the education sector conducted in Lesotho in 2003 by the Ministry of Education and Training, with support from UNICEF has laid the basis for the department to address issues related to gender equality in the education system. The ministry has since conducted gender sensitization campaigns in eight out of the ten districts in the country and established over 20 Girls' Education Movement (GEM) clubs with the participation of an estimated 600 girls and boys. The clubs address issues of access, retention and quality education. They also serve as anti-AIDS clubs and work closely with teachers and other community members to support orphans and vulnerable children.

The abolition of formal and informal school fees is a key measure to ensure that girls, and particularly orphaned girls, do not drop out of school. Governments will have to work out how to deal with the economic implications of abolition. Some countries are already implementing or suggesting creative alternatives, including providing economic support to schools in communities particularly affected by HIV/AIDS (e.g. Namibia, Swaziland), cash grants to poor families, or income generation opportunities for girls. There are other immediate measures that countries within the region can take to improve girls' access to schooling and the quality of education they receive once there, and ultimately contribute to the empowerment of girls and to transforming gender relations.

Flexible learning options such as double-shift systems, multi-grade teaching, distance education and minimum packages for learning need to be closely examined. Conventional schooling and rigid curricula are not conducive to ensuring quality education for girls, particularly orphans or those in households with sick caregivers. In Zambia, the Interactive Radio Initiative (IRI), which uses radio to educate children from vulnerable communities and households, is proving that infrastructure is not necessary for solid learning. With little more than radios and community 'mentors' to guide their radio learning activities, Zambia's IRI children post stellar results at each grade level, out-performing their peers in 'regular' schools.

There is an urgent need for collaboration and communication among governments, schools and communities to establish norms on preventing and responding to sexual abuse, violence and harassment in schools. This should include clear reporting guidelines, training of counsellors, teachers, students and parents, as well as communication strategies and legal frameworks and policies.[70]

Girls must be empowered to speak out about abuse and harassment, and communities, schools and the justice system need to listen to and protect them. All teachers need to know their responsibilities in relation to reporting abuse. Teachers' unions could play an important role in this process, as well as in ensuring increased knowledge among teachers about HIV/AIDS and gender.

Industrialised countries need to do more to reduce or compensate for the movement of skilled staff in the public sector from developing countries. Schools should put in place effective strategies to mitigate the impact of AIDS and such "brain drain" on staffing, so that these do not pose an obstacle to dealing with teachers that abuse.

National guidelines for the integration of gender into life-skills education, adopted in some Task Force countries, must be implemented and complemented by gender training for teachers.

Schools need to rethink their own roles as community resources. They can, for example, provide opportunities for girls (and boys) to participate in sports, drama and other extra-curricular activities that

will keep them healthy and occupied. Young people have proven themselves to be tremendously resourceful in planning and managing such initiatives.

Community Dialogue on girls' education: Mnjolo Community, Malawi
Discussion with traditional leaders revealed that girls' drop-out could be attributed to traditional practices such as initiation ceremonies and their ramifications, and the impact of HIV/AIDS. It was decided to use HIV/AIDS as an entry point to get the Mnjolo community to discuss cultural practices affecting girls' participation in education. Two trained facilitators living in Mnjolo are supporting a community dialogue led by the chief with the support of other local leaders and involving all community members, including parents, teachers and school committees. Routine gatherings (e.g. markets, evening storytelling sessions, meetings of parents and teachers associations) are used as opportunities for discussion of the community's responsibility for analysing the reasons for drop-out among girls and identifying ways of keeping them in school. As a result of this dialogue, community members all committed themselves to keeping girls in school, school facilities were improved to include recreational facilities for both boys and girls, and the curriculum was expanded to include life-skills education. As a result school enrolment increased by about 50 per cent and no drop-outs were recorded.

RECOMMENDATIONS:

Key Recommendation:
The Task Force recommends that, governments, in collaboration with communities and development partners:

- By March 2005 conduct a thorough gender-sensitive assessment of the feasibility of flexible schooling options in vulnerable communities as well as the subsidizing or abolition of school fees. Governments should ensure that related costs such as textbooks and uniforms are kept to a minimum.

Further Recommendations:
The Task Force recommends that by March 2005, governments, in collaboration with communities and development partners:

- Support schools to develop, make known, and implement clear policies and guidelines for addressing child sexual abuse, including by teachers.

- In countries that have not yet done so, formalise life-skills education with an emphasis on a broad range of social competencies, ensuring that such programmes are extended to cover out-of-school young women and young men.

- Revise existing nationally approved life-skills curricula to include a module on gender roles and relations, including empowerment of girls, and masculinities, beginning in Grade 4.

3. Violence against women and girls

"I don't hate men, I just don't trust them and I don't think I could depend on a man for much. I don't hate sex either… I just don't attach that much importance to it. You wouldn't understand, you've never been raped. …I don't think the trauma sank in immediately, but then I just couldn't seem to get any control in my life, and when you have been raped, you feel so helpless that all you want is to be able to gain back that control. But I didn't know how. And then the self-hate set in. … So what did I do? Casual sex, lots of it. I had one-night stands..."

- "Tina", 23-year-old Zambian woman, who was raped at age 18 by someone she knew and trusted[71]

The Context of Gender-Based Violence in Southern Africa

The high levels of violence in southern Africa are often attributed to the legacy of recent civil wars and of apartheid, with its destabilising effect beyond the borders of South Africa. This history intersects with the legacy of colonialism and indigenous patriarchy to the detriment of women in powerful ways. During country visits, stakeholders also highlighted the link between substance abuse and violence as one of their most pressing concerns.

Domestic Violence

"Beating is an answer to disputes with your wife. My daughter-in-law doesn't need family conferences. I advised my son to beat her up."

- Elderly man, peri-urban lowlands, Lesotho[72]

Violence by an intimate partner is one of the most common forms of violence against women. According to the World Health Organisation (WHO), globally between 10 and 69 per cent of women have reported experiencing physical abuse by a partner, often accompanied by verbal and/or sexual abuse.[73]

The full extent of the problem in southern Africa is difficult to measure as most countries do not collect statistics on domestic violence. However, the studies and surveys that have been done point to high levels of violence. A Zimbabwean study, for example, notes that domestic violence accounts for over 60 per cent of murder cases in the Harare courts.[74] In South Africa, a study in three provinces found that between 19 per cent and 28 per cent of women reported having been physically abused by an intimate partner, with between 4.5 per cent and 7 per cent reporting having been raped.[75] In Namibia, a recent WHO study found that one in five women had experienced physical or sexual abuse in the preceding year; 62 per cent of these survivors did not seek help.[76]

The ingrained acceptance of domestic violence[77] is illustrated by a media interview with a diplomat based in the Zambian capital, Lusaka.

> "He said domestic fights were common in homes and, even as educated and enlightened as he was, admitted to 'roughing up' his wife a couple of times in their 19 years together. He did not know of any wife who could say she had never been slapped or beaten by her husband.
>
> 'In the earlier years of marriage when we [men] are still immature, we tend to use force instead of reason, but a beating should never be so severe that that a wife runs away or reports you to the police.'… A father of two daughters, he hopes they will have husbands who are not violent, but is certain that at one point 'they will receive a slap'.[78] "

Evidence suggests that domestic violence is so endemic and normalised that women themselves often believe that wife beating is acceptable (see graph below). Focus group discussions conducted in Lesotho by WHO revealed that both women and men, including policemen, seem to accept domestic violence as a natural consequence of blameworthy behaviour on the part of women, who are also seen as responsible for ending such violence (see box).[79]

Blaming women for domestic violence, Lesotho[80]

"The woman is sometimes at fault and the husband is forced to beat her." - Woman, rural foothills

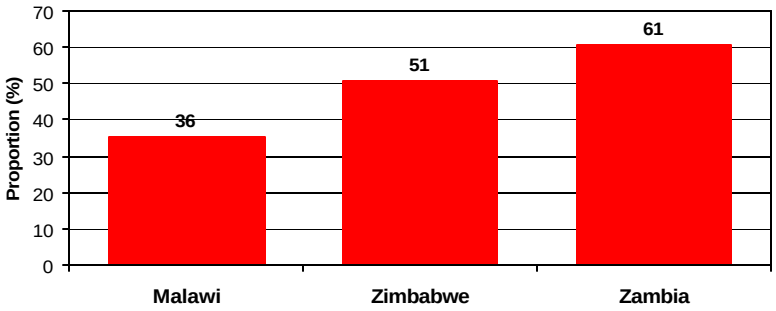
"A man can beat his wife if there is some misunderstanding in their discussion. Men see beating as a solution to most problems in the family."- Woman, rural highlands

"The solution of violence is that women should listen to their husbands. They don't realize that they were born to be heads of the family." - Elderly man, peri-urban lowlands

"Women can lead a healthy life if they recognize that this is a man's world and this cannot be changed. So they should stop being freedom fighters." - Policeman, urban lowlands

Large proportions of married women agree with at least one reason* for wife beating.

Percentage of women who agree with at least one reason justifying a husband hitting or beating his wife, Malawi, Zimbabwe, Zambia 1999-2002



*Question asked was: "Sometimes a husband is annoyed or angered by things which his wife does. In your opinion, is a husband justified in hitting or beating his wife in the following situations"?

Categories - The reasons justifying a husband to beat his wife included in the survey are 'wife burning the food', 'arguing with husband', 'going out without telling the husband', 'neglecting the children', and 'refusing sexual relations'. In Zambia categories were slightly different.

Source: Malawi, 2000; Zimbabwe, 1999; and Zambia DHS, 2001/2002

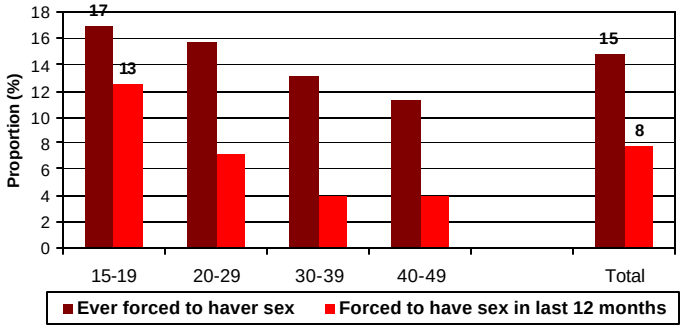
Sexual violence

High levels of sexual violence are also reported in the region, with teenage girls and younger women particularly at risk. As illustrated in the graph below, one in eight teenage girls in Zambia report ever having been forced to have sex by a man at some time in the last twelve months.[81] In a study in KwaZulu Natal in South Africa, 34 per cent of girls aged 15 – 19 reported that they were either persuaded (20 per cent), tricked (4 per cent) or forced (10 per cent) into their *first* sexual intercourse.[82]

Again, as with domestic violence, women and girls may be blamed for sexual violence. In Botswana, South Africa, Zambia and Zimbabwe both boys and girls participating in a UNICEF study expressed the opinion that girls who dressed in what was seen as provocative ways (tight jeans, miniskirts) were seen as 'bad girls' who were too '"modern' and immoral and invited rape.[83] Women and men in Lesotho echoed this with such statements as: "Often rape comes as the result of loose behaviour of women. Maybe a woman is wearing a short dress and is sitting with legs apart in the presence of men." Even a policeman stated that "[s]ome women call for it by the way they dress."[84]

One in eight teenage girls report having been forced to have sex by a man in the past 12 months, Zambia, 2002

Percentage of women who have ever been forced by a man to have sexual intercourse, and percentage who were forced to have intercourse in the past 12 months, by age, Zambia 2001-2002



Source: Zambia DHS - 2001/2002

Sexual violence by an intimate partner and marital rape

"If a husband demands sex after beating his wife, it is a way of apologizing and it shows that he still loves you."

- Elderly woman, rural foothills, Lesotho[85]

Contrary to conventional notions women are more likely to be raped by an intimate partner, spouse or someone else they know than by a stranger, and the abuse often continues over a relatively long period of time. In Zimbabwe, for example, one in four women report ever having experienced sexual violence by an intimate partner. [86]

The issue of marital rape is a particularly thorny one across the sub-region. Judicial officials in Botswana and Malawi have recently said that husbands cannot rape their wives as consent to sex is given upon marriage. [87] Although women's groups continue to lobby for marital rape to be outlawed, in more than half of Task Force countries, legislation does not deal with marital rape. Even where marital rape is outlawed, justice can remain elusive. As a woman testifying in parliamentary hearings in South Africa stated:

> "… What must we do? Go to the police? Even if you are raped by a stranger they don't believe you and now you must tell them that your husband is raping you? They are just as bad as the husbands….You can have scars on your face…bleeding…and police still send you home to 'sort it out with him'. Rape by your husband is only real in the law."[88]

Lack of recourse

In this context it is not surprising that, despite the existence of laws criminalising sexual violence and (in some Task Force countries) domestic violence, women are reluctant to report violence, given the attitude of the police and courts, fear of the personal consequences of reporting, limited access to support, and importantly, ignorance of the existence of laws criminalizing sexual violence and (in some Task Force countries) domestic violence.

It was clear from country visits that police officers, prosecutors, magistrates, judges and other judicial officials rarely receive the training they require to handle violence cases sensitively. "Survivor-friendly" judicial systems, particularly those catering for children, do exist in South Africa and Zimbabwe, but they are rare elsewhere in the region. As a result, even when perpetrators are brought to court they are often not convicted or receive light sentences. In many instances the wheels of justice turn slowly – particularly traumatic for women and girls who reside in the same home or community as the perpetrator.

Supporting Survivors of Violence in Botswana
In Botswana, the Task Force country visit included visits to two initiatives that aim to support survivors of violence. The Kagisano Women's Shelter Project in Gaborone assists women and their children who are survivors of domestic violence by providing them with temporary shelter, counselling and support 24 hours a day. One thousand kilometres away, in Maun, Women Against Rape (WAR) provides support, assistance and counselling to survivors of sexual violence, but does not have the facilities to provide shelter. As a result, they must sometimes refer clients to the Gaborone shelter. Other WAR programmes include providing training on violence, HIV/AIDS and human rights in primary and secondary schools; working with communities to handle the first steps to get recourse in cases of violence and working with the prison system on a study of perpetrators, seeking to learn why they commit rape and eventually to develop counseling programmes for them.

Many women stay in abusive relationships because they cannot afford to leave. Task Force countries have made very few resources and almost no facilities available to support women who do attempt to leave abusive partners. In South Africa there are a number of shelters, but most are under-resourced. In Botswana, Namibia, Zambia and Zimbabwe, Task Force working group members could confirm the existence of only one shelter in each country that specifically caters to the needs of abused women. None of these shelters received funding from the State. In, Lesotho, Malawi, Mozambique and Swaziland, Task Force members were unable to identify a single shelter or house of safety.

Links between Violence and HIV infection

1. Violence may result in HIV infection
Violence against women and girls makes them vulnerable to HIV in three ways:[89]

i) Direct transmission through forced or coerced sexual acts;
ii) Unsafe sexual behaviour in later life; and
iii) Fear of violence within relationships.

i. Direct transmission through sexual violence
According to the WHO, "[v]iolent or forced sex can increase the risk of transmitting HIV. In forced vaginal penetration, abrasions and cuts commonly occur, thus facilitating the entry of the virus – when it is present – through the vaginal mucosa."[90] In most Task Force countries post-exposure HIV prophylaxis (PEP) is beginning to be available on a limited basis to women and girls who have been raped. The country visits revealed, however, that women often lack information on PEP and service providers often lack training or the authorisation to dispense it. Girls who are legal minors may face added obstacles in receiving PEP.

ii. The link between sexual assault and subsequent risky sexual behaviour
Sexual assault doesn't only result in unwanted pregnancies, sexually transmitted infections (including HIV), low self-esteem and depression. It has also been proven to be associated with risk-taking sexual behaviour in later life.[91] Studies in the United States have found a significant correlation between childhood sexual assault and such behaviours as:

- early initiation of sexual activity;
- number of sexual partners;
- sex with a known risky partner;
- sex while intoxicated;
- receptive anal sex;
- abuse by a partner as an adult;
- STI history; and
- engaging in sex work.[92]

When this information is considered in light of the high rates of sexual violence in Southern Africa, the implications for girls' personal development and growth, as well as their long-term risk of infection are devastating. This phenomenon is not adequately reflected in current prevention strategies. The reality in

all countries in the sub-region seems to be that girls who are abused engage in far riskier sex than their counterparts, crying out for help rather than the blame they often encounter.

iii. Fear of violence

In relationships characterised by violence and forced sex, women and girls often find themselves unable to negotiate safer sex or insist on fidelity on the part of their partner, for fear of provoking further violence.[93]

2. HIV infection may result in violence

Not only can violence result in HIV infection, but HIV/AIDS can lead to violence.

i) Violence as a result of disclosure of HIV status

Recent studies have come to conflicting conclusions about the likelihood of violence upon disclosure of HIV status. Yet while further research is needed in this area, it is clear that disclosure may lead to violence in some circumstances. Because women are often the first to test for HIV through ante-natal services, they are routinely blamed for bringing disease into the household (or community). As a man from rural Zambia put it:

> "She will be blamed, saying you have given it to your husband but meanwhile it is the husband who has given it to her. I might transmit the disease to my wife then tell my wife to go for an AIDS checkup. If she is found positive I blame it on her and tell the whole community that she has infected me."[94]

During the country visits a number of NGOs suggested that this blame easily turns to violence and that many women and girls who disclose their HIV status to partners, family members and communities are physically and emotionally abused as a result. Some are even killed, as illustrated by two high profile cases in South Africa in recent years – Gugu Dlamini was killed in December 1998 by members of her community after disclosing her HIV status, and in December 2003, a horrific sequel saw the murder of South African AIDS activist Lorna Mlosana after she disclosed her status to the men who had just gang-raped her.[95]

ii) Violence as a result of the increased burden of care

Anecdotal evidence suggests that violence often increases in the home when household tasks cannot be completed due to the time taken to care for sick family members or because the caregiver herself is ill or when households are affected by economic and food insecurity. Again this is an area requiring further study.

MOVING FORWARD

On a positive note, in all countries that have enacted legislation addressing gender-based violence, there is an increase in the reporting of rape and sexual assault. Several countries have units within the police that deal specifically with domestic violence and sexual abuse of women and children. Many of these units have dedicated and hard-working police officers who take pride in their efforts to combat sexual abuse. Increasingly many units are including counselling and access to emergency health services and referrals in their services, in order to make life easier for the women and children they serve.

In a number of Task Force countries (including Botswana, Namibia and Zambia) organisations are experimenting with the idea of 'one-stop' facilities, which are already available at over 90 sites across South Africa. Such facilities should allow women to access in a single location all the services they require in cases of domestic violence or sexual assault, including police officers, social workers, counsellors and health workers who can dispense PEP. Where these services are available, they must be made widely known and easily accessible.

Furthermore, there is a growing lobby of men who have joined the struggle to end violence against women, recognizing that this is a serious development challenge.

Men for Change, South Africa
Men for Change (MFC) is a South African organisation established to encourage men to become involved in ending gender-based violence, particularly domestic violence. MFC conducts gender-awareness workshops, including sessions with sexual offenders in prisons, and offers counselling and support services for perpetrators. MFC also conducts an intervention programme with the justice system entitled 'Men overcoming violence', focusing on rehabilitation of perpetrators. MFC has also conducted training on gender, masculinity and the social context of gender-based violence in South Africa, Namibia and Zimbabwe. MFC's approach is to work with men to become agents for change in their communities.

All Task Force countries have witnessed growing outrage from all sectors of society, including the media, about sexual violence against under-age girls. This outrage should be transformed into action by linking communities with local services, such as child protection units within the police, supported by gender sensitisation and training. It is also to be hoped that popular sentiment around child abuse will lead to intensified efforts to combat all forms of violence, including against adult women.

At a broader level, it will be necessary for some of the Task Force countries to examine the linkages between gender-based violence and other forms of abuse and violence experienced by communities. It is only by properly examining the underlying issues that fuel crime and violence in the sub-region that communities will become safe for women and men alike.

Women and Law in Southern Africa - Action on Gender-Based Violence in Mozambique
Throughout the region, national chapters of Women and Law in Southern Africa (WLSA) are active in conducting research and advocacy on issues of women's legal rights, particularly related to property rights and gender-based violence (GBV). The Mozambique branch of WLSA is currently engaged in research on the feminization of HIV/AIDS and has produced a report on gender-based violence.[96] The report looks at the experiences of survivors of violence in police stations and the justice system. This research will feed into a range of actions organised by WLSA in partnership with UN agencies (in particular WHO) and others to increase awareness, skills and capacity to respond to gender-based violence. Activities include training police officers, teachers, humanitarian assistance workers and law enforcement officers in handling and preventing sexual exploitation of women and children; a GBV pilot initiative covering training of health workers and monitoring programmes in selected health centres; a national campaign against sexual abuse and violence; a survey on GBV; support for the Ministry of Women and Social Action to coordinate the implementation of a national plan for prevention of GBV; and efforts to influence the lengthy ongoing process of legal reform to the penal code and family law.

RECOMMENDATIONS

Key Recommendation:
The Task Force recommends that the United Nations support partners to:

- By December 2004, conduct research into the costs and feasibility of establishing counselling services for girls who have experienced sexual violence, in order to address their trauma and prevent the long-term consequences (including risky sexual behaviour) that may result in HIV infection.

Further Recommendations:
The Task Force recommends that governments and development partners:

- By March, double the funding available to women and girls seeking safe havens from abusive homes; provide grants to such institutions to allow them to provide services (legal, health and socio-economic), and establish such structures where there are none.
- By December 2004, begin an assessment of the justice and health systems with a view to identifying institutional stumbling blocks to women's and girls' access to justice and health services, in order to establish survivor-friendly courts and health services (including 'one stop' facilities) by 2006.
- Consider putting in place by July 2005 policies and procedures related to screening for violence against women and girls as part of all voluntary counselling and testing services.

4. Property & inheritance rights of women and girls

"We live here [in a one room shack] now because of my husband's death. His parents no longer consider me related to them, and two years ago they forced me from the house that my husband and I built."
- Joyce Giya, mother of three, whose husband died of AIDS, Malawi[97]

Law and Custom
In the notorious case of *Magaya v. Magaya*, the Zimbabwe Supreme Court ruled unanimously that Venia Magaya could not inherit her deceased father's estate. According to the judges, only men can inherit under customary law and all family members are subordinate to the male head of the family - "Women should never be considered adults within the family, but only as a junior male or teenager."[98]

Most Task Force countries have dual legal systems that recognise both customary and common law depending on the circumstances. In most instances, when women marry according to customary law they join their husband's clan and property devolves along the male line. Women access property through men – fathers, husbands, brothers, sons or male cousins.[99] The fact that men pay dowry (brideprice or "lobola") upon marriage strengthens their hold over women and property.

Before southern Africa was colonised, land was supposed to be controlled by elders for the benefit of the entire community, including women. This changed with the advent of colonialism, which superimposed concepts of private property and a rigidly patriarchal system on an already patriarchal traditional property dispensation. Since then the principle that men administer and inherit property to the benefit of the clan has been transformed into claims of individual property ownership without any corresponding obligation. The result is that, in southern Africa, customary law is often interpreted in ways that effectively deny women their fundamental rights to own or even access property.[100]

In most countries laws controlling property ownership (e.g Deeds Registry Acts) exist in some form, but are often flawed and almost always inadequately enforced. In some Task Force countries women remain legal minors upon marriage, unless they are married out of community of property, a rare practice.

Dispossession
Without the enforceable right to own or inherit land and property, women and girls face destitution after the death of their husbands, partners or parents, while poverty and economic dependence leave them exposed to increased sexual exploitation and violence.

Examples of women dispossessed of property by in-laws upon the death of their husbands were recounted during all country visits and are borne out by studies done by WLSA, the Food and Agricultural Organisation (FAO) and others. In the words of Melody Kunene, a 35-year-old Swazi woman, "[s]ometimes if you marry in the traditional way your husband's family says his property belongs to them, and they leave you with nothing." Stakeholders interviewed during country visits asserted that this phenomenon is on the increase in both rural and urban areas as the death toll from AIDS mounts and poverty worsens.[101] But women don't have to wait to be widowed to be dispossessed - disclosure of HIV status to a spouse sometimes ends with a woman being thrown out of her home.[102]

Lack of Recourse
Even though legal protections exist in some countries, the reality is that most women are left without recourse. Fear of violence, the social stigma of pursuing a claim, and being considered greedy or a traitor to one's culture, serves to keep many women quiet.[103]

For those women who do try to fight back, navigating the complex systems of land administration in many countries requires time, literacy and large doses of patience, as well as money for transportation and accommodation in regional centres where offices are located. Lack of police intervention also makes it difficult for women and girls to prevent dispossession or have their property and assets returned, as does the bias and indifference they face from prosecutors, magistrates, judges and other officials who have not received adequate training in the relevant laws or sensitisation to women's rights.

A major contributing factor to the dispossession of women and girls is lack of knowledge of their rights or support for pursuing claims for restoration. During country visits, the Task Force working group learnt of a handful of initiatives by determined organisations that provide legal education and advice to women regarding property rights. These organisations assist women in recovering lost property and in finding alternative means of living. These initiatives have to get by with very little funding or external support, and are hampered by a shortage of trained paralegals and by regulations restricting their operations.

Some CBOs and NGOs are working to encourage and educate men and women to write wills that protect the rights of their spouses and children. However, the Task Force found that such programmes encounter a number of difficulties. In many cultures speaking about the impending death of a loved one implies 'calling death to the house'.[104] During country visits, stakeholders also pointed out that written wills are often perceived as "against African culture" and do not always accord with complex rules of property ownership or deal adequately with the circumstances of polygamous families. As a Malawian woman put it, "you can't split a bicycle three ways."

Harmful Traditional Practices

In some traditions, inheritance is intertwined with such practices as "widow inheritance" and sexual "cleansing". Because a woman joins her husband's clan upon marriage, she may be required to marry one of her husband's male relatives upon his death to retain this link with the clan and her claim to any property. Traditionally this implied a responsibility on the part of the man to ensure the well-being of the woman and her children, but it now mainly appears to be a way of gaining possession of the property of the deceased. It appears from conversations in various Task Force countries that this practice is on the wane across the region, as is the practice of sexual cleansing, by which a widow is required to have sexual intercourse with a male family member of her deceased husband in order to release evil spirits left behind after his death. Because of an increasing recognition of its violation of women's rights and the risk of HIV transmission, many traditional leaders are replacing this practice with less harmful alternatives.

MOVING FORWARD

There is an urgent need to raise awareness about women's and girls' rights to own and inherit property. This involves education and training (including media campaigns) of women, girls, traditional leaders, local authorities, local administrators, justice officials, paralegals and communities at large. This should go hand-in-hand with increased funding to organisations providing legal advice and assistance to women who have been dispossessed.

Justice for Widows and Orphans in Zambia

The Justice for Widows and Orphans Project in Zambia, a network of nine organisations, focuses on providing legal education to women and orphans at the community level, in the context of support groups. The focus is on property and inheritance rights, including the 1989 Wills and Administration of Testate Estates Act. Continual meetings and workshops are also held with traditional leaders and communities on human rights and inheritance rights. The project works closely with local NGOs and CBOs and has good working relations with the police.

There is also a need to raise awareness, in a culturally sensitive and coherent manner, of the importance of will-writing in the context of HIV/AIDS. The police and judicial administration officials must be expected to protect women's rights and must be trained to respect and uphold laws in situations where women are being victimised. In addition, land administration systems must be overhauled so that they are more accessible to rural people, particularly women.

For all of this to happen, traditional authorities and leaders must become partners in the fight against AIDS. They have a key role to play in mediating disputes within their communities and supporting women in their efforts to recover property. As keepers of the traditions and laws of African cultures, these authorities are in a position to reinterpret customary law to enhance the protective aspects of tradition in ways that complement common law and protect women's rights. For example, the Ondonga traditional leaders in Namibia amended their customary law after extensive discussion to provide that women should remain on land after the death of their husbands.

Denial of women's rights to own and inherit property is a violation of their human rights as enshrined in CEDAW, which has been ratified by all Task Force countries, except Swaziland. It is critical that the countries of southern Africa enact laws that protect women's rights and protect women who assert their rights through the legal system from retaliatory action. But such legal reforms, and the eventual enforcement of laws, can be cumbersome and time-consuming, since they depend on sufficient financial and human resources and political will. Action at the local level cannot wait while this process is underway.

Legal Assistance Centre, Namibia
The Legal Assistance Centre (LAC) provides legal advice and assistance to victims of property grabbing and has conducted litigation on behalf of both male and female children. LAC has also conducted educational workshops on property grabbing for communities, NGOs, social workers, traditional leaders and women victims. LAC has developed training materials on will-writing and plans to develop training materials, which could be used at the national level. LAC also plans to set up a national programme in collaboration with government ministries and NGOs and to establish a network on inheritance issues. Their aim is to facilitate collaboration between government and NGOs and provide training to government and NGO staff on property stripping, while providing direct support to NGOs. LAC has run paralegal training for the last three years, including sessions on property and inheritance.

RECOMMENDATIONS

Key Recommendation:
The Task Force recommends that local government authorities, in close consultation with traditional leaders, local justice officials and civil society groups:

- By December 2005, put in place mechanisms to facilitate protection against dispossession for women and girls; restoration of taken property, alternative shelter and livelihoods for those who have been dispossessed; and training of paralegals to provide education and assistance.

Further recommendations:
The Task Force recommends that governments, with support from the United Nations and development partners, by March 2005:

- Set up national commissions involving traditional leaders and civil society organisations to investigate property rights. Among the topics to be studied should be the reasons for restrictions on the exercise of women's property rights; the evolution and discriminatory provisions of customary law; means of protecting women's rights to land and property; and better definition of who should intervene in this area and at what level. Based on this investigation, national commissions should, by July 2006, codify, revise and strengthen traditional laws and practices to protect and promote the rights of women and girls in the context of HIV/AIDS.

- Begin the process of amending or repealing all legislation that violates women's property ownership and inheritance rights. Adequate legislation will normally include a presumption of spousal co-ownership of family property and of equal division of property upon the termination of marriage and/or death in the event that a will is not in place. Such legislation should also include provisions that affirm women's equitable rights to own property and land irrespective of marital status.

- Begin to develop property and land adjudication and administration systems that are accessible, decentralised, efficient and gender-sensitive, and have initiated campaigns to make these systems well known and understood;

- Issue guidelines on the incorporation of counselling and education on property and inheritance rights and succession planning into secondary school curricula, marriage preparation and counselling, and/or voluntary testing and counselling programmes. These guidelines should include such issues as inheritance planning, will writing, guardianship of children, and, where feasible, saving money for the future care of their dependants.

5. The Role of women and girls as care-givers

"Our grandmother is so wonderful. She helps us in so many ways. She feeds us, dresses us and brings us up properly. When we see her, we see our mother… We are so grateful that she is still with us."
- Catherine, 15, the eldest of eight grandchildren being cared for by their 80-year-old grandmother Irene, in Malawi[105]

The Gender Division of Labour
The traditional gender division of labour clearly differentiates between 'men's work', which is seen primarily as work outside the home for payment, and 'women's work', which revolves mainly around the household– taking care of children, cooking, cleaning and other domestic chores, as well as subsistence farming. Women are more likely than men to take on additional roles in the community, often voluntarily and in their 'free time'.

Although women work significantly longer hours than men – taking into account both household work and income-generating activities – the reality is that men's work is valued while women's work is not.

Boys and girls are socialised into these roles from a young age. Boys and girls interviewed in Botswana, South Africa, Zambia and Zimbabwe as part of a regional UNICEF study hold strongly stereotyped views of gender roles in terms of labour, with both boys and girls considering domestic work to be 'girl's work'. Despite the fact that girls tended to work more than boys, with less freedom or time for recreation, the general perception among boys and girls was that boys were more suited for hard work than girls. Because of homophobia and fear of ridicule, boys are particularly invested in these stereotypes and few would admit to doing any work that could be seen as "girlish". Kizito, an adolescent boy from Zambia is an exception, but pays the price: "I sweep in the house, clean plates and cook. My friends laugh at me and call me girlish names such as Mary or Maggie. For that reason I do not have many friends."[106]

Impact of HIV on Women's Labour and Care Roles
"What happens is that woman will just keep working, because no one else does chores and sometimes for the sake of the children the women will do the housework despite her illness"
- Elderly woman, rural foothills, Lesotho[107]

AIDS has increased the responsibilities of women and girls at both the household and community levels. A recent study in South Africa revealed that two-thirds of caregivers in the households surveyed were female. 7% of caregivers were under the age of 18 and almost a quarter of them over the age of 60 – most of them women.[108]

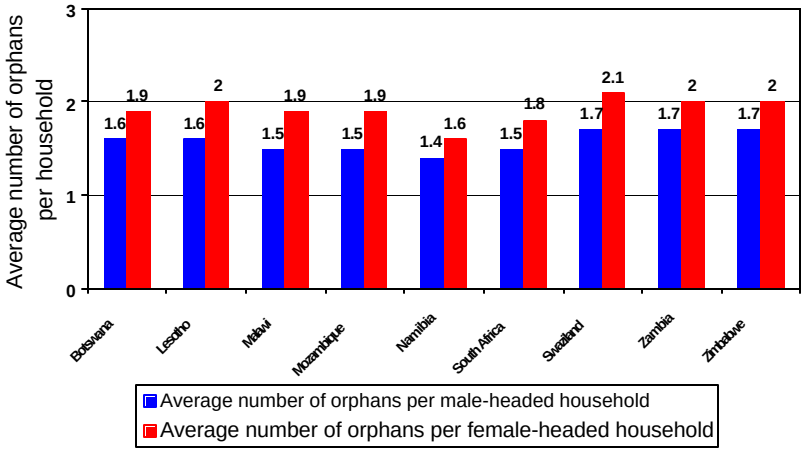
While care is often narrowly defined as attending to the sick and dying in the home and community setting, it in fact embraces a wide range of other responsibilities, including emotional and mental care, care for children who have lost one or both parents, and palliative care. Such work is often labour-intensive, exhausting and emotionally draining. Both health-care workers and community and home carers experience feelings of helplessness and frustration when they do not have sufficient medication to alleviate the suffering that constantly surrounds them. Very few programmes exist to address their psycho-social and physical needs.

Women care for those affected by HIV/AIDS in three spheres:

i) Women as home carers
Women usually bear primary responsibility for taking care of sick family members in the home, doing the cooking, cleaning and arranging hospital and clinical care for the sick. The Task Force noted that it is common for women who are sick to be sent back to their natal family to be cared for by female family members. When men are sick, however, it is expected that the wife or a female family member will do the caring.

Female-headed households take in more orphans than male-headed households

Average number of orphans cared for by female- and male-headed households



Source: Africa's Orphaned Generations, UNICEF/UNAIDS, 2003

Orphans are more likely to end up in a household headed by a woman than in one headed by a man, even in cases where their mother has died. In Zambia, for example, twice as many female-headed households take care of double orphans (those who have lost both parents) than do male-headed households. Moreover, as the above graph shows, female-headed households generally assume care of more orphans per household than those headed by males. As the death toll mounts, these women are increasingly older, with grandmothers now caring for far more orphans than they did a decade ago.[109] In Botswana, for example, grandmothers care for 51 per cent of children who have lost their fathers and 53 per cent of those who have lost their mothers.[110] This burden is particularly heavy in a context where women - particularly older women - are more affected than men by poverty.

Increasingly also, children are taken out of school to care for younger siblings when parents are sick or have died. More research is needed to establish whether girls are more likely to fulfil this role, or whether it is usually the eldest sibling, regardless of gender.

ii) Women as professional carers

The majority of nurses, social workers and teachers are women. Nurses' caseloads are getting heavier and during country visits some health workers expressed despair that hospital wards were becoming hospices for the terminally ill. A recent study in South Africa showed that 46 per cent of public hospital patients are HIV-positive and that AIDS patients have started 'crowding out' other patients.[111] At the same time there are fewer nurses to meet escalating service demands, as many leave for high-income countries where they receive better compensation and experience less stress. Because of this toll on health-care professionals, people living with HIV/AIDS are not currently receiving the dignified care they deserve.

iii) Women as community carers

Many HIV/AIDS-related programmes are premised on the involvement and contributions of communities. In reality, however, it is women and girls who give their time and labour (usually on a volunteer basis) for faith-based or other community groups, to support sick neighbours, friends and relatives, as well as orphans and vulnerable children.

The Question of Volunteerism

It was clear from the country visits that the care provided in the community in both urban and rural areas is often provided by volunteers, the vast majority of whom are women. In Swaziland, for example, the Task Force spoke with three (unpaid) women volunteers at a neighbourhood care point, who feed and

look after orphans and vulnerable children seven days a week, from 8 a.m. to 4 p.m., out of sheer good will.

Throughout the sub-region there is little recognition or compensation for carers who may experience exploitation, high levels of burn-out and low social status. In all countries, stakeholders pointed out that they may even face discrimination as "just volunteers" within the NGOs or CBOs for which they work, while men commonly occupy a majority of the salaried or decision-making positions. Many women receive no incentives or stipends for the work they do, despite the fact that often the caregiver is as poor as the people she is assisting.

This is a situation that many people in both communities and NGOs find increasingly unacceptable. There is a need to re-think the budgeting of community resources. Current programmes are highly subsidised by women's labour and the capacity of women and girls to support the sick and care for families is simply assumed to be infinite. As AIDS deaths escalate, this is becoming an increasingly untenable situation for women and girls.

Impact of Care Roles on Income

In the abovementioned study undertaken in South Africa, 40 per cent of households reported that the primary caregiver had taken time off from formal or informal employment or schooling because of caring responsibilities, thus impacting negatively on the economic situation of the family and the school attendance of girls. 60 per cent of caregivers took time off from other housework or gardening growing food for consumption or sale. Primary caregivers also experience severe emotional strain.[112]

At a community level, a number of income-generating activities have been developed in order to mitigate the impact of AIDS on the economic status of individuals or households affected by AIDS. Although many agencies specialise in micro-credit, enterprise and entrepreneurship, many of the more recent innovations in thinking about livelihoods and sustainable development have not yet been applied to communities affected by HIV/AIDS. Many communities are struggling with small-scale, badly planned projects that never find a market and do little to alleviate poverty in any sustainable way. As one woman from the National Zambian Positive People's Association (NZP+) pointed out during the country visit,

> "We have received skills training and money for income generation. We make red AIDS ribbons and doormats. But we have no market. We have failed. We don't know where to go once we have the skills. How do you get information about marketing possibilities without money, without transport, without even a telephone? We want to work. Money is coming into the country because of HIV, but why is this money not coming directly to us? Look at the number of children we take care of."

Male participation

Men's participation in care-giving and domestic work would significantly alter the burden of care on women – a fact often overlooked in debates about care. It was apparent from country visits that men tend to become involved in home or community caring when they are actively recruited or receive training or remuneration. Their roles are often restricted, however, to tasks that require physical strength, such as turning patients or gathering firewood, while women still tend to do the hands-on caring, cleaning and feeding.

MOVING FORWARD

During the country visit to South Africa, it was suggested that a Volunteer Charter be developed, which would clearly articulate the rights and responsibilities of home-based carers and family members caring for people living with HIV/AIDS and other chronic illness. Such a charter should be based on the idea that women and men providing home-based care deserve to be treated with respect by communities and the NGOs to which they are affiliated, and that they should benefit from standardized working hours, remuneration, psycho-social support and other protections.

Women must be supported in their caring roles in the community and home through provision of commodities such as gloves, bleach and food, as is already happening in some Task Force countries. Botswana, Namibia and South Africa also have comprehensive social protection measures to support

older people and those caring economically for orphans. The administrative procedures for accessing such pensions and child-support grants should be streamlined, however, as older women in particular find them difficult to access. The feasibility of such measures needs to be studied in other Task Force countries.

Innovative ways for communities to share the load must be explored, including planting of community gardens, caring for children in groups, and joint preparation of food.

In all these areas men must play a greater role. Active efforts are needed to recruit men into home-based care and other support programmes within communities and to socialise boys in ways which allow them to take on these roles. Men in families where partners are sick must be supported to play the role of primary care provider for their families – including children.

More must be done to prevent burn-out among caregivers and help them deal with the stress, grief and trauma associated with caring. For example, at the Perinatal Research Unit at Baragwanath Hospital in Soweto, South Africa, a vigil was held in October 2003 to bring together family members and carers who had experienced the death of someone they cared for in the previous year. While the gesture did not cost much money, its significance in terms of recognising the pain and trauma experienced by care providers has not gone unnoticed. Other organisations, such as the Nurses' Association of Swaziland, are planning 'caring for carers' interventions, with support group and counselling components. Psychosocial care for children who must deal not only with the illness and death of parents but also with the economic stress and burdens of care presents a particular challenge.

The economic empowerment of girls and women living with or otherwise affected by HIV/AIDS is a priority, particularly those in female-headed households. Far more must be done to ensure that these women and girls have sustainable livelihoods for them so that they are able to better protect themselves against HIV infection and deal with its impact.

Sustainable livelihoods projects in Malawi and Zambia

Swaziland Positive Living for Life Organisation, an organisation for people living with HIV/AIDS and affected families, offers an example of a strategic approach that addresses many of the concerns raised by the women of NZP+. Members are engaged in economic activities such as the production of cash crops, (maize, beans and ground nuts), vegetable seedlings and poultry, and the sewing of school uniforms and track-suits. They have developed local markets, targeting homes in the neighbourhood and schools within the communities. SWAPOL members also sell their maize to the national maize marketing association. Approximately 50 per cent of the profits go back into the project, 25 per cent to members, and 25 per cent to an orphans' trust fund they established.

During the country visit to Malawi, the team visited Ndawambe village, which runs several Integrated Livelihood projects. These include bee-keeping, bakery, fish farming, mushroom production, cooking oil refining, juice extraction and livestock production. Most products are sold within the village. The entire community benefits from working on some aspects of the project and young people handle sales in town. The village is also home to 155 orphans, including two child-headed households, and has trained volunteer groups to provide HIV/AIDS-related counselling, promote voluntary counselling and testing services (VCT) and support home-based care. Ndawambe reports no record of violence against women as a result of the partnership between men and women in economic activities. The involvement of all members of the community has increased collective commitment to all social issues. Sustainability is ensured by the fact that the village is not dependent on a sole product, but conducts multiple activities involving all members of the village.

Income-generating initiatives based on artistic or indigenous handicrafts need to be made much more lucrative by introducing modern methods for increasing production, organizing women's leadership for the establishment of cooperatives, and support to identifying not only local, but also external markets in countries where such 'ethnic' handicrafts are considered rare and attractive.

RECOMMENDATIONS

Key Recommendation:

The Task Force recommends that Governments, with the support of development partners:

- By July 2005, develop and widely disseminate a Volunteer Charter that outlines the rights and responsibilities of volunteers and the government departments, NGOs, CBOs, governments and donors with whom they work;

Further Recommendations:

The Task Force recommends that Governments, with the support of development partners:

- By March 2005, determine the economic feasibility of the provision of social grants and/or other support programmes or mechanisms to older caregivers (at an appropriate age).

- By the end of 2004, establish national guidelines for support to care-givers (both health-care workers and community members) that provide clear steps organizations must take to protect the mental and physical health of people caring for terminally ill patients. Such guidelines should address the prevention of new infections among home-based care workers and health-care workers as well as the provision of counselling and psycho-social support.

The Task Force recommends that Governments and civil society:

- Actively recruit and train men into home-based care programmes.

- By March 2005 develop high-quality manuals for care and support in the home, with a view to training home-based carers and traditional healers and disseminating the manual on an ongoing basis.

6. Care and treatment for women and girls

"When there is money, we borrow a bicycle and push her to the clinic"
- Josephine, 76-year-old mother of Edna, who has TB, Zambia[113]

Recent years have seen sustained activism by a number of AIDS service organisations, most notably the Treatment Action Campaign in South Africa, around the right of all people living with HIV/AIDS to care and treatment, and the obligation on the international community to make treatment affordable to the governments of developing countries. At the same time, pilot programmes such as the one run by Médecins sans Frontières (MSF) in Khayelitsha, South Africa, have convinced governments and international agencies that cost-effective treatment is possible in resource-poor settings. Together with increased resources, such as those made available from the Global Fund, this has resulted in more outhern African countries following the example of Botswana and deciding to roll out anti-retroviral treatment nationally through their public health systems.

Women's Access in Africa
International studies show that men tend to enjoy better access to HIV/AIDS care and treatment where AIDS treatment is located within the private sector, and through drug trials. This is because men usually have a greater ability to pay for treatment and have higher rates of employment and access to medical insurance. In addition, researchers have demonstrated a reluctance to enrol women in drug trials because of the potential side-effects should they become pregnant.[114]

However, in the African context, women clearly have more access than men to Highly Active Antiretroviral Therapy (HAART), as they tend to have more contact than men with public health institutions, particularly as most referrals to HIV/AIDS care come through antenatal services. Programmes for the prevention of mother-to-child transmission of HIV (PMTCT) are being implemented or expanded in Task Force countries, but these usually consist of short-term AZT or single-dose Nevirapine treatment to prevent HIV transmission in infants. They do not provide longer term care and treatment for women and may in fact compromise future options for treatment through the risk of drug resistance.

In addition, overall access to treatment for both men and women remains low. And for many women and girls significant gender-based barriers to access remain, including stigma, discrimination and violence.

Barriers to Care and Treatment

i) Stigma and Discrimination
Because of gender norms, women and men experience stigma and discrimination differently. Women, like men, face discrimination because of the virus that is in their blood. But women are more likely than men to be blamed for bringing the virus into communities and families. According to a group of women from the South African chapter of the International Community of Women living with HIV/AIDS, (ICW):

> "We are often blamed for bringing HIV into the marriage or home, or for infecting our children. There are perceptions in society that see women as responsible for HIV – this is because most of the statistics in the media are of women."[115]

The converse may also be true – the fact that there is still little access to treatment in the sub-region is seen as a significant barrier to openness and acceptance by men and women of their HIV status.

ii) Age
Girls face significant barriers in accessing treatment, as legislation often does not allow for young people under the age of eighteen to give consent to testing or treatment, even in the context of prevention of mother-to-child transmission interventions. This can be a particular problem for orphans, who may not have guardians or identification documents. Girls, who account for a large proportion of pregnancies in southern Africa, are also often marginalised and stigmatised in antenatal care settings because of censure of early pregnancy, potentially compromising their care.

iii) Violence

As discussed elsewhere in this paper, many women refrain from getting tested or accessing treatment because of the fear of violence when their status becomes known. According to Thandiswa Yibatha, a woman enrolled in the MSF Khayelitsha programme,

> "After [my child] Unathi died I tried to see if I could tell my boyfriend about the HIV. He said he would take a gun and shoot me and himself if we were HIV-positive, so I decided not to tell him."

As a result Thandiswa had another child who died of AIDS and delayed getting treatment herself because of her partner's inability to face the truth.

iv) Lack of access to voluntary counselling and testing (VCT) services

Most people living with HIV do not know their HIV status. Since VCT is the entry point for treatment, it is critical that VCT sites are established in communities throughout each country. In some Task Force countries, there are still very few sites, too few to serve even the existing population of people who may wish to be tested, let alone the large number who will seek services as treatment programmes are rolled out in the coming years. Many VCT services are under-resourced, and many counsellors lack the skills and basic training necessary to provide quality services.

Currently, most women who know their status find out through antenatal services. Access to VCT still poses a significant challenge for girls and women who do not seek reproductive health services, and a more severe challenge still for men, who generally are far less likely to use public health facilities than women,.

Comprehensive Care

There has been a clear recognition of the fact that treatment for opportunistic infections should be part of a comprehensive package of HIV/AIDS related health care services. Women and men with symptoms of HIV-related disease (including those living in situations of insecurity or conflict) do not always have timely access to appropriate health-care services, regardless of whether they may eventually have access to HAART. HIV-positive women face the additional challenge of accessing reproductive health and family-planning services responsive to their particular needs.

Some opportunistic infections can be treated relatively cheaply in a home-based care setting, but this may pose challenges for women, who, as we have seen, are usually cared for by other women. As the epidemic matures, and the older women who provide much of the family-based care begin to die, many women will be left to fend for themselves. Despite being ill themselves, women in AIDS-affected households are often still expected to keep the household going, care for children and nurse sick partners.

MOVING FORWARD

To respond to the shortcomings of traditional PMTCT programmes, including lack of male involvement, the Mailman School of Public Health at Columbia University is coordinating the MTCT-Plus Initiative, with sites in Mozambique, South Africa and Zambia. Through these programmes, women receive continued care and treatment, as do their partners and children. This includes treatment education, counselling and psychosocial support. Similar initiatives are also being piloted in other Task Force countries. Such PMTCT+ initiatives are showing promise in ensuring care and treatment for more women, while reducing stigma, discrimination and the risk of violence, and promoting gender equity, by extending these services to members of their households, including male partners. Stronger links must be operationalised between these initiatives and national HAART programmes, as these are rolled out.

Reaching out to men in Zambia

The country visit to Zambia included a visit to the Chelstone Clinic, one of the MTCT-Plus pilot sites. The clinic is experimenting with creative ways to increase uptake of services by male partners, including services on weekends and holidays and outreach by male peer educators who talk to men where they gather, such as at drinking places and sports events.

A breakthrough over the last year has been the WHO's announcement of its "3 x 5" Initiative, which aims to provide access to treatment to at least three million people living with HIV/AIDS by 2005. The Initiative will accomplish this goal by using multiple entry points, in addition to ante-natal care services.

In rolling out treatment, WHO highlights the need to focus on 'urgency, equity and sustainability.' Using these core principles, the initiative aims to act quickly to extend treatment, while recognising the need to ensure fairness in developing the criteria that determine who gets medicine and under what conditions, and working to strengthen service delivery systems at the same time. The initiative will use multiple entry-points for treatment, to ensure access to those not accessing ante-natal care services.[116] This should have a positive impact on men's access to treatment.

Particular attention should also be paid to ensuring access to treatment for health workers and teachers, in order to help address the weakening institutional and human capacity experienced by all Task Force countries.

As the MSF project in Khayelitsha illustrated, anti-retroviral (ARV) treatment can be effective in resource-poor settings. However, it is also clear from the case of Botswana, that large scale roll-out of VCT and HAART is facilitated by health systems that are functional. This includes adequately trained health workers, investment in laboratory services, and systems for drug procurement, management, monitoring and accounting. Governments and their partners cannot wait for all of these measures to be in place before fulfilling the rights of their citizens to treatment. They will need to continue strengthening and reinforcing broader health care infrastructure as roll-out proceeds. In addition, as upgrades occur, more women-friendly services must be introduced within the public sector. Access to health services in situations of conflict or insecurity requires urgent attention.

Women currently represent the bulk of those accessing treatment. It is to be hoped that more men will receive care and treatment as more channels for testing and treatment are identified. At the same time, those responsible for ARV roll-out programmes must ensure that men do not access treatment at the expense of women, but rather that equity is achieved and maintained.

RECOMMENDATIONS:

Key Recommendation:

The Task Force recommends that governments, with development partners:

- By March 2005, develop national standardised sets of gender-sensitive training modules for VCT counsellors, including clear guidelines and information on gender-based violence, partner notification and confidentiality.

Further Recommendations:

The Task Force recommends that governments and development partners:

- Ensure gender equity in access to a minimum of 50 per cent of the resources programmed under the Global Fund to fight AIDS, TB and Malaria; MAP, WHO's 3 X 5 initiative and other initiatives that aim to promote access to comprehensive care, including HAART.

- Strengthen sexual and reproductive health services, as an entry point to women's access to HIV treatment and care through improved referral systems, information, education and communication interventions, and Management Information Systems.

- Ensure that girls under 18, including orphans, are not barred from voluntary counselling, testing, and treatment because of the lack of consent by a guardian, or a lack of proper identification.

- Strengthen in a phased manner existing health facilities at the district and provincial levels, in order to provide comprehensive and affordable services, including HIV/AIDS treatment, specifically addressing women's and girls' access to health services.

CONCLUSION

It will be critical in the next few years to ensure that gender inequality is recognised and addressed as a central driver of the HIV/AIDS epidemic. If not, the situation will worsen, and the ability of women – particularly the elderly and the very young – to cope will completely disintegrate.

As illustrated throughout this report, the challenges facing women and girls are complex. Yet this is not an excuse for inaction. As the orphan crisis deepens, and as more and more women and girls take to the streets in search of ways to survive, it will be impossible to ignore the importance of gender-transformatory strategies.

The complexity and the long-term nature of gender inequality cannot stand in the way of progress and change; nor can tradition and culture stand still. The efforts of governments and communities should be aimed at developing equitable ways of addressing HIV/AIDS, which respect women and girls as full members of society.

The statistics on infection rates are in themselves cause for alarm, but so too are the circumstances of girls and women who have sex for too many reasons other than love and self-respect.

The challenge will be to ensure that these statistics and social realities do not paralyse us. Instead, this report, together with the growing body of evidence supporting the findings of the Task Force, should spur governments, communities and families to action.

Without leadership on this aspect of the epidemic, many southern African communities will not survive. With firm leadership all the challenges presented in this report can be resolved.

Women's leadership and the support of governments and civil society groups are critical in this regard. Turning the tide must be the result of movements that are rooted in the experiences of women and arise from the genuine recognition of communities that the situation must change.

Women and men in the region must want gender equality as badly as they want an end to the epidemic. It is only brave leadership that will plant the seeds of a movement rooted in respect and a desire to improve the lives of all Africans.

The United Nations has an important role to play in achieving this. In particular, the United Nations system can facilitate partnerships between civil society, governments and international agencies, providing information and technical support where it is needed, and offering to bring together disparate groups. By establishing and then monitoring standards for how we will respond to women and girls, the UN can play a critical behind-the-scenes role as facilitator.

Most importantly, women, communities, governments, the UN, other multilateral organisations, private foundations and bilateral organisations can take concrete steps to support the processes that will be necessary to achieve the recommendations contained within this report.

ANNEX 1: CONCEPTUAL FRAMEWORK

Putting Gender Back into the Picture

The Task Force endorses a gendered approach to understanding the problems of women and girls. This approach has borrowed heavily from the work of Geeta Rao Gupta. Gupta's "Conceptual Framework for Assessing HIV/AIDS programmes"[117] forms the basis of much of the Task Force's thinking as well as its recommendations. Gupta suggests that existing HIV/AIDS programmes fall into five broad categories:

First, many programmes focus on *stereotypes* of women and men. These programmes promote images of men as forceful and powerful (for example, condom promotion focusing on male assertiveness),[118] while women are portrayed as 'powerless victims'. They often depict sex workers as a source of infection, and feature messages such as "good girls wait to have sex". Such images and messages reaffirm the idea that men are active in sexual relationships and women are passive and confirm stereotypes that prevent women and girls from asking questions or speaking out about their sexuality. They often also (incorrectly) identify marginalised groups (such as sex workers or truck drivers) as the driving force behind the spread of the virus. Stereotypical programmes also often focus on women and men from marginalised communities and portray them in a negative (often racist or ethnically unacceptable) light.

The second type of programmatic response is referred to as *gender-neutral*. These programmes are aimed at the general population and do not distinguish between the different needs of women and men. These types of programmes include messages such as 'Abstain, Be faithful or use a Condom' ("ABC"). While these programmes do not seek deliberately to exclude women, they are often based on research and messages that have been tested on men, or work better for men. Gupta suggests that a gender-neutral approach 'does no harm.' On the other Hand, Tallis[119] argues that they are often harmful and need to be challenged. This is largely because the bulk of AIDS programmes fall into this category. This means that most of what women and girls hear and learn about HIV/AIDS through peer education, or through the mass media, does not wholly apply to them. This has the overall effect of leaving women and girls under-equipped to protect themselves against HIV infection.

The third category examines *gender-sensitive* programming. Gender-sensitive approaches respond to the different needs and constraints of individuals based on their gender and sexuality. Many current AIDS programmes operate at this level, where women's practical needs are identified and attempts are made to meet those needs through service delivery. Examples of gender-sensitive programmes would include those that provide the female condom or focus on income generation or increasing women's access to health services. Other types of gender-sensitive initiatives work with men by providing education that is based on their roles as decision makers in their relationships with women. Such programmes often help men to look at how they can make better, safer decisions to protect themselves, their female partners and their children. However, they do so within the paradigm of men's roles as providers and heads of the household.

Traditionally, gender-sensitive programmes also include an element of empowerment, ensuring that women are part of project decision-making structures, and providing training that helps women to build assertiveness and skills, with an emphasis on participation. Gender-sensitive programmes impact on the immediate lives of women, but seldom directly challenge the gender status quo. In this regard, they fail because they do not question men's ability to hold decision-making power and use their masculinity to control the sexuality and rights of their partners.

While Gupta includes *empowerment* as a particular category of programmes, Tallis suggests that empowerment can be seen as an end in itself, as well as a means to an end – i.e. the transformation of gendered power relations. When women and men are empowered, they are able to take the necessary actions at various different levels – personal, group/collective, 'community,' institutional and broader societal – to confront, address and shift the inequality within gender power relations.

The last category of programmes in Gupta's model is the *transformational* approach, the key objective of which is to transform gender relations between women and men so that they are equitable. Gupta argues

that transformational programmes focus on radical change at the personal, relationship (including the redefinition of heterosexual relations), community and societal levels. Transformational programmes address the systems, mechanisms, policies and practices that are needed to support such genuine change.

Transformational approaches include changing laws such as those governing property and inheritance, domestic violence and marital rape, changing the attitudes of men and women about male and female behaviour, and empowering women to access credit, employment and other opportunities for broader development.

Is Gender Transformation Possible?

Transforming society in order to realise the rights of women and men to healthy and productive lives is a long-term goal. Within many NGOs, there is contention about whether HIV/AIDS programmes should focus only on being gender-sensitive, or whether they should attempt to challenge the status quo and ensure that women and men achieve equity and equality.[120]

For governments and for the United Nations, there can be no debate. The right to equality has been enshrined in international law since the Universal Declaration of Human Rights. Additional rights have been guaranteed by such instruments as the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), and the Convention on the Rights of the Child (CRC). These rights form the basis of the commitments made by governments in the Declaration of Commitment of the United Nations General Assembly Special Session on HIV/AIDS in 2001. The Declaration states:

> *"Empowering women is essential for reducing vulnerability.*
> By 2003, … have in place in all countries strategies, policies and programmes that identify and begin to address those factors that make individuals particularly vulnerable to infection including…. poverty, lack of empowerment of women, lack of education, social excusion, illiteracy, discrimination, lack of information and/or commodities for self-protection, and all types of sexual exploitation…. Such strategies, policies and programmes should address the gender dimension of the epidemic, specify the action that will be taken to address vulnerability and set targets for achievement."

It is on the basis of these instruments that the Task Force makes its recommendations. The Task Force recognises that the challenges facing women and girls are not simply about how best to programme for their needs. They are fundamentally about their human rights. Using a human rights-based approach has allowed activists and governments alike to use widely respected instruments to advocate for the human rights of people living with or affected by HIV/AIDS. It has placed clear obligations on governments to respect, protect and fulfil these rights. And it has ensured that women, girls, men and boys have a say in decision-making, ensuring more strategic, structural interventions.

MOVING FORWARD

Throughout this report, the Task Force highlights the necessity of finding realistic strategies that address the twin challenges of HIV/AIDS and gender inequality. The focus of the report is informed by an analysis that suggests that there are several levels on which all concerned actors should be working. The first is the personal level of self-esteem and confidence for women and girls, and respect and self-awareness for men and boys. The second level involves the formulation of laws and policies that are non-discriminatory. The third level focuses on the provision of accessible primary and sexual and reproductive health services for all women and men.

As this report uncovers the findings of the regional assessment, the focus is on ensuring that each of these levels is appropriately addressed. At the same time, the report points to critical macro issues that must be addressed if the needs of women and girls are to be met in the midst of the crisis wrought by AIDS.

Annex 2: List of Task Force members

1. **Hon. Dr. Libertina Amathila** , Minister of Health and Social Services, Namibia
2. **Hon. Ruth Bhengu**, Member of Parliament, Kwazulu-Natal, South Africa and Deputy President, South African National Civic Organization (SANCO)
3. **Justice Lombe Chibesakunda**, Judge of the High Court of Zambia
4. **Dr. Vera Chirwa**, Executive Director, Malawi CARER
5. **Hon. Dr. Brian Chituwo**, Minister of Health and Chairman, Cabinet Committee on HIV/AIDS, Zambia
6. **Dra. Teresinha da Silva**, President, Forum Mulher, Mozambique
7. **Thuli Dladla**, Director, SEBENTA National Institute, Swaziland
8. **Justice Unity Dow**, Judge of the High Court of Botswana
9. **Prof. Musa Dube**, Consulting Theologian, World Council of Churches Member, Circle of Concerned African Women Theologians *****
10. **Ms. Tandiwe Dumbutshena**, Headmistress, Harare Girl's High School, Zimbabwe
11. **Mr. Selby Gama**, Principal Magistrate, Swaziland
12. **Ms. Siphiwe Hlophe**, Coordinator, Swaziland Positive Living for Life Organisation (SWAPOL) *****
13. **His Royal Highness Nkosi Patekile Holomisa**, Chairperson, SADC Council of Traditional Leaders and President, Congress of Traditional Leaders of South Africa (Contralesa) *****
14. **Dr Bongani Khumalo**, Chairman, Transnet, South Africa
15. **Prof. Nkandu Luo**, Chairperson, Society for Women and AIDS in Zambia
16. **Rt. Hon. Justin Malewezi**, Vice President, Malawi
17. **Ms. Keiso Matashane Marite**, Women and Law in Southern Africa (WLSA), Lesotho
18. **Ms. Bella Matambanadzo**, Executive Director, Zimbabwe Women's Resource Centre and Network *****
19. **Ms. Kate Mhambi-Musimwa**, National Coordinator, Zimbabwe AIDS Network (ZAN)
20. **Mr. Diogo Milagre**, Deputy Executive Secretary of the National AIDS Council and Vice-President, Forum Mulher, Mozambique
21. **Mrs. M'athato Mosisili**, First Lady, Lesotho
22. **Ms. Promise Mthembu**, Global Advocacy Officer, International Community of Women living with HIV/AIDS *****
23. **Ms. Masuka Mutenda**, Programme Manager, Youth Media, Zambia *****

24. **Ms. Maria Nangolo-Rukoro**, Country Director, National Social Marketing Programme, Namibia

25. **Dr. Naomi Ngwira**, Executive Director, Institute for Policy Research for Analysis and Dialogue, Malawi

26. **Dr. Khauhelo Raditapole**, Member of Parliament and Chairperson, HIV/AIDS Parliamentary Committee, Lesotho

27. **Prof. Sheila Tlou**, HIV/AIDS Coordinator, University of Botswana

**** Task Force members invited by regional Task Force working group, not country teams***

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it is measurable. Laws that are discriminatory or treat women and men differently can be identified and taken off the books. In this way, equality has been a critical tool for women's empowerment in many countries. However, the definition has been criticized by some who argue that equality implies a sameness between women and men and therefore discounts the social and biological differences between women and men that sometimes make it necessary to treat women and men differently but fairly. Gender equity takes into account the social differences between women and men in order to produce equivalent life outcomes for both. For example, in a society that values boys over girls, teacher preference often results in higher educational achievement for boys than girls. A gender equity approach recognizes this reality as discriminatory and then puts in place measures to overcome the bias against girls. A gender equitable solution to this problem will usually require a positive measure - sometimes called affirmative action - to neutralize the effect of discrimination. For example, a gender equity promoting solution to the problem outlined above would be to propose different criteria for university admittance for girls and boys. Girls' essays might be judged as more important than poor mathematics scores, or participation in extra curricular activities – possible for boys because they have fewer domestic responsibilities – would be weighted as less important for girls than for boys. These measures may not always address the root cause of the problem – that institutions and people discriminate against girls - but they do add a measure of fairness to the process of applying to university by seeking to redress the gender imbalances of the educational system.