I. CONTEXT

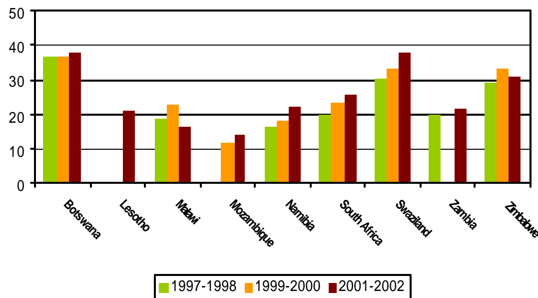
"The railway line that goes through this town links Mozambique with South Africa and Zimbabwe. During the war in the 1980s, the trains were guarded by soldiers from those countries. There were shortages of food in those days and the relief supplies would come into Mozambique on those trains. Many of 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

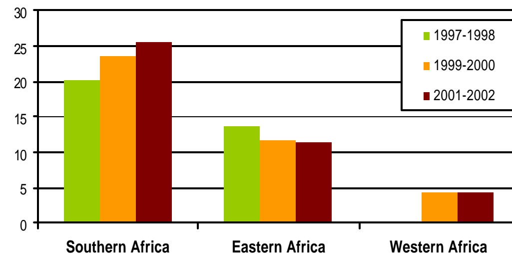
Trends in HIV prevalence among women attending antenatal care clinics in Southern Africa, 1997-2002



*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

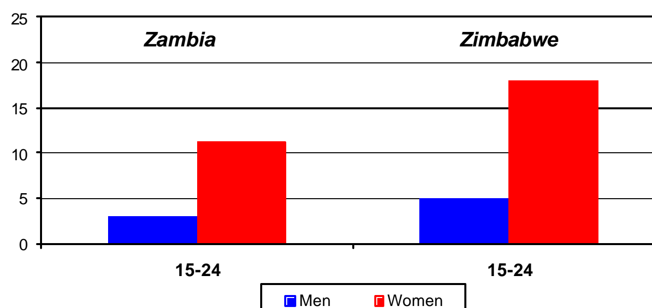


*Source*HIV/AIDS Epidemiological Surveillance Update for the WHO African Region 2002. World Health Organization, Regional Office for Africa, Harare, Zimbabwe, September 2003.

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.