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.

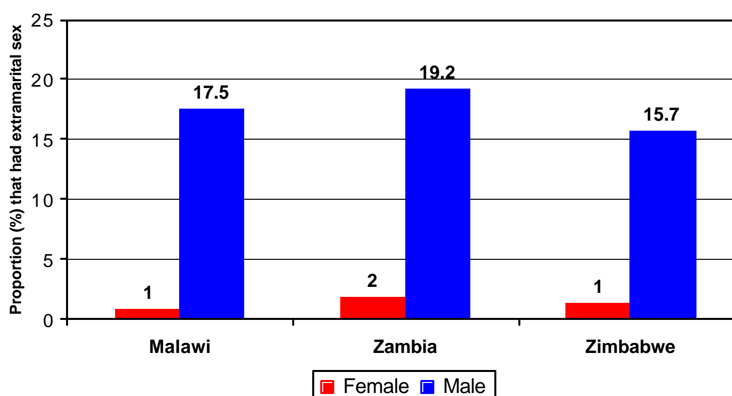
Women are biologically more vulnerable to HIV infection than men, as they have a greater surface area of mucous membranes exposed to the virus during sexual intercourse. Girls are particularly vulnerable, as their membranes have not yet developed fully and are permeated easily (while immature genitalia 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."



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

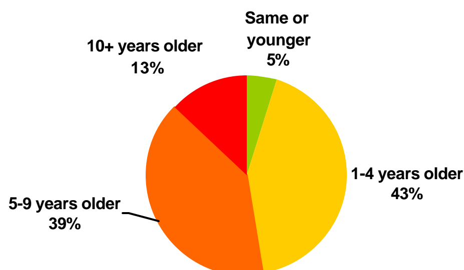
"For most people the gifts are a form of bribery to having sex with them. If one does not agree into sex, she feels that the boy may think that she do not love him, I just wanted his presents."
- Adolescent girl, Botswana[38]

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

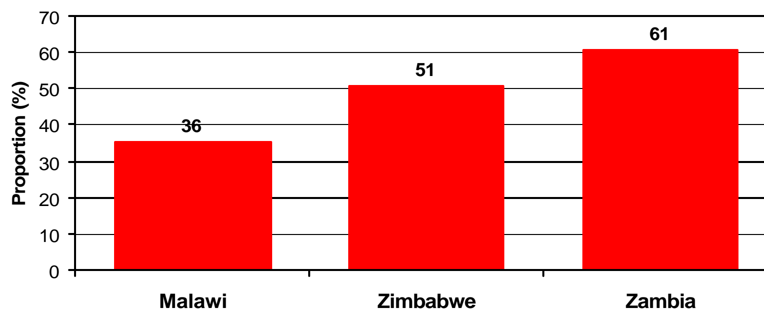
"A man can beat his wife if there is some misunderstanding in their discussion. Men see beating as a solution to most problems in the family."- Woman, rural highlands

"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

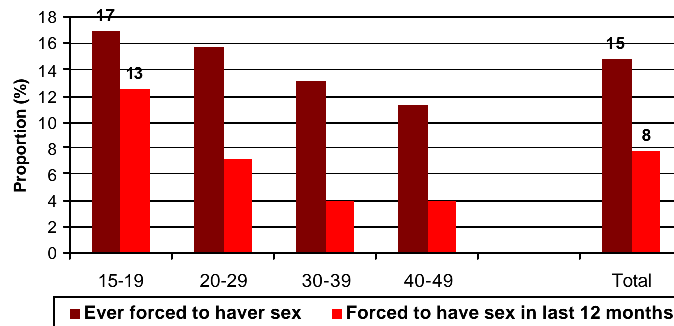
Sexual violence

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 esult 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.

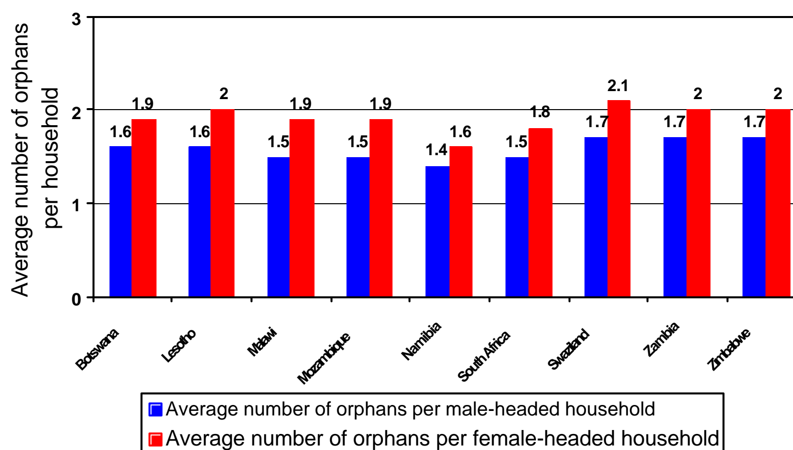
Women care for those affected by HIV/AIDS in three spheres:

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.