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Review of Progress
Secretary-General's Task Force on Women, Girls and HIV/AIDS in Southern Africa, 2003-2007

Working Draft
Summary Report
June 2007

Presentation of policy guidance to address gender issues

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This document presents the preliminary findings of a review of progress in strengthening national AIDS programmes for women and girls in the nine countries that participated in the United Nations Secretary-General's Task Force on Women, Girls and HIV/AIDS in Southern Africa. The full and final report, which will include country reports and recommendations, will be released in October 2007.

INTRODUCTION

1. The situation of women and girls in the context of the HIV epidemic in Sub-Saharan Africa has been, and continues to be, a cause of major concern. The statistics are extremely disturbing: women comprise 59% of adults (aged 15-49) living with HIV in sub-Saharan Africa. Seventy-five percent of all young people living with HIV in the region are female. HIV prevalence amongst young women aged 15-24 is three times higher than HIV prevalence amongst young men in the same age group.[1] Three-quarters of all adult women living with HIV in the world reside in sub-Saharan Africa.[2]

2. In Southern Africa, the figures are even more alarming. Nearly forty percent of all women living with HIV live in the nine countries of Southern Africa, with the largest number of women living with HIV residing in South Africa.[3] In South Africa, death rates from natural causes for women aged 25-34 years increased five-fold between 1997 and 2004; whereas for males aged 30-44 they doubled.[4]

3. In 2001, the statistical disparities in HIV prevalence between women and men were highlighted at the United Nations General Assembly Special Session on HIV/AIDS where Member States declared that "women and girls are disproportionately affected by HIV/AIDS", and committed themselves, among other things, to implement by 2005 "national strategies that: promote the advancement of women and women's full enjoyment of all human rights; promote shared responsibility of men and women to ensure safe sex; empower women to have control over and decide freely and responsibly on matters related to their sexuality to increase their ability to protect themselves from HIV infection."[5]

4. In 2003, Heads of State and Government in the countries in the Southern African Development Community themselves committed to "strengthening initiatives that increase the capacities of women and adolescent girls to protect themselves from the risk of HIV infection…including sexual and reproductive health and prevention education that promotes gender equality within a culturally and gender sensitive framework".[6]

5. That same year, in the report of a joint mission to the region, the then Executive Director of the World Food Programme and UN Secretary General Special Envoy on HIV/AIDS confirmed the need to urgently do more for women in the context of the epidemic, stating that "very little is being done to reduce women's risks, to protect them from sexual aggression and violence, to ease their burden or to support their coping and caring efforts". They recommended that an "immediate, strongly led and broadly implemented joint effort to act on gender and HIV/AIDS must be initiated without delay. The effort should feature leadership from the United Nations, the active engagement of governments and substantially increased support to civil society

[1] 2006. UNAIDS. 2006 AIDS Epidemic Update.
[2] 2006. UNAIDS/Global Coalition on Women and AIDS. Keeping the Promise: An Agenda for Action on Women and AIDS.
[3] 2006. UNAIDS. 2006 AIDS Epidemic Update.
[4] Ibid.
[5] 2001. United Nations Declaration on HIV/AIDS, paragraph 59.
[6] 2003. SADC. The SADC Declaration on HIV and AIDS, section 1(c), page 5.

organizations, including remarkable grassroots initiatives."[7] Responding to this recommendation, UN Secretary General Kofi Annan established the Secretary General's Task Force on Women and Girls and HIV/AIDS in Southern Africa (Task Force). [8]

6. The Task Force comprised twenty-seven eminent persons from government, civil society and the private sector who had demonstrated leadership on gender and HIV in each of the affected countries.[9] The countries involved were the nine countries in southern Africa that had the highest HIV prevalence rates: Botswana, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Zambia and Zimbabwe. In the first instance, the Task Force sought to raise awareness amongst policy-makers, governments, civil society and the media about the alarming impact of HIV on women and girls in Southern Africa. Secondly, the Task Force sought to build consensus around acknowledgement that gender inequalities – issues of violence against women, property grabbing, social norms around sexuality, age differences in relationships – were fuelling HIV transmission and inhibiting effective AIDS responses at country level. Thirdly, the Task Force sought to provide a solid conceptual framework, as well as concrete policy and programmatic guidance, to address the impact of HIV on women and girls and to spur action at country level.

7. Based on trips to all nine countries, the Task Force issued a powerful report in 2004 which provided detailed analysis of the gender-based vulnerabilities of women and girls to HIV and made specific, concrete, recommendations. Recommendations were made regarding the **leadership** of governments, the United Nations system, and donors, and in the context of six **focus areas**:

   - **Preventing HIV in girls and young women** – stopping new infections in women and girls through interventions aimed at intergenerational sex and the cultural and socio-economic empowerment of women and girls
   - **Getting girls in school and keeping them there** – ensuring continued enrolment and retention of girls in school
   - **Ending violence against women** – protection of girls and women from exposure to HIV through sexual violence and intimidation
   - **Securing property and inheritance rights** – protecting women's and girls' right to own and inherit property
   - **Supporting improved community-based care** – protection against exploitation and provision of support in bearing the burden of care for people affected by HIV
   - **Equitable access to care and treatment** – ensuring equal access to care and treatment and protection from stigma, discrimination and violence related to women's HIV status.[10]

[7] United Nations, "Mission Report: Lesotho, Malawi, Zambia and Zimbabwe, 22-29 January 2003, Mr. James T. Morris, Special Envoy of the Secretary-General for Humanitarian Needs in Southern Africa and Mr, Stephen Lewis, Special Envoy of the Secretary General for HIV/AIDS in Africa.
[8] See "Facing the Future Together, Report of the United Nations Secretary-General's Task Force on Women, girls and HIV/AIDS in Southern Africa", 2004. http://womenandaids.unaids.org/regional/docs/Report%20of%20SG%27s%20Task%20Force.pdf
[9] See Annex I: List of SGTF Members.
[10] See "Facing the Future Together, Report of the United Nations Secretary-General's Task Force on Women, girls and HIV/AIDS in Southern Africa", 2004, http://womenandaids.unaids.org/regional/docs/Report%20of%20SG%27s%20Task%20Force.pdf

> "The Task Force recognizes that the challenges facing women and girls are not simply about how best to programme for their needs. They are fundamentally about their human rights. Using a human rights-based approach has allowed activists and governments alike to use widely respected instruments to advocate for the human rights of people living with or affected by HIV/AIDS. It has placed clear obligations on governments to respect, protect and fulfill these rights. And it has ensured that women, girls, men and boys have a say in decision-making, ensuring more strategic, structural interventions."[11]

8. The Task Force report and recommendations were issued publicly and widely disseminated in the region. National working groups were established in each country in order to develop national reports of the Task Force on the situation of women, girls and HIV. In most countries, the national report of the Task Force led to the development of a multi-stakeholder national Action Plan on women, girls and HIV based on the report. In many countries action plans were costed, and coordinating committees were established to support the implementation of these plans.

9. The Task Force and its work was one of the most significant efforts to address the gender dynamics and inequalities that lie at the root of the vulnerability of women and girls to HIV in Africa. The Task Force process comprised many of the key elements often cited as necessary for moving an agenda forward, including high level political commitment from government, civil society and UN agencies, and the development of national Action Plans sponsored by country-based national teams.

10. Because of the importance of the work of the Task Force on behalf of women and girls confronting HIV in Southern Africa, the UNAIDS Secretariat took the opportunity of the June 2006 decision on gender by the UNAIDS Programme Coordinating Board[12] to review progress in the countries which participated in the Task Force. It was felt that: (a) important lessons could be learned about responding to gender challenges in national AIDS programmes from the Task Force experience, and (b) that the participating countries could benefit from further support for the implementation of the recommendations of the Task Force. This paper comprises a working draft summary of the initial findings of this review which is still on-going. It presents the methodology of the review, initial country findings, and a set of preliminary conclusions emerging from the review. It is intended that the full and final report, with individual country reports and recommendations, will be available in October 2007. Comments to this working draft are welcome.[13]

Methodology

11. In the third quarter of 2006, the UNAIDS Secretariat, including the Secretariat of the Global Coalition on Women and AIDS, undertook the following actions:

    - Identified funding for a review of the Task Force countries' progress on addressing gender equality in national AIDS responses.
    - Identified a partner that could assist in undertaking this review.

[11] 2004. UNAIDS/UNICEF. Facing the Future Together: Expanded Report of the United Nations Secretary General's Task Force on women, girls and HIV/AIDS in Southern Africa, p. 48.

[12] In June 2006, the UNAIDS Programme Coordinating Board requested that "UNAIDS, in partnership with national governments, conduct a gender assessment of three to five national AIDS plans and in addition submit to the Programme Coordinating Board, at its 2007 meeting, technical and policy guidelines to address gender issues in a practical way for use by governments, national AIDS programmes, donors, international agencies, the UN system and nongovernmental organizations in response to the increased feminization of the epidemic. (Decision 7.10)

[13] Please send all comments to Judy Polsky at UNAIDS, polskyj@unaids.org

- Connected this review, to the degree possible, with the other efforts to respond to the Programme Coordinating Board's request to UNAIDS to conduct gender and HIV assessments and produce gender and HIV guidelines.

12. The project was supported by funding from the Global Coalition on Women and AIDS, and the partner chosen was the Open Society Initiative on Southern Africa (OSISA).[14] Relevant staff from OSISA became a part the expert group that worked together to respond to the June 2006 decision of the UNAIDS Programme Coordinating Board.[15]

13. In February 2007, OSISA undertook desk reviews of developments in each of the nine countries focussing on key national documents, processes and research reports on gender and HIV. In March and April 2007, these desk reviews were followed by visits to six of the nine countries: Botswana, Lesotho, Malawi, Mozambique, South Africa and Swaziland.[16] The country visits consisted of approximately five days in country, and were supplemented by telephone calls and key informant interviews with Government, UN officials and members of civil society. (See Annex II for the organizations contacted during the review.)

14. The are no official indicators and/or ready-made data-sets to measure progress on advancing gender equality in the context of HIV responses or discerning where programming has been adapted to serve the specific needs of women/girls or men/boys. Furthermore, the Task Force was intended as an advocacy initiative designed to inspire action on gender and HIV at country level, rather than an initiative to implement programmes. However, the Task Force noted in its report that, "Although girls and women represent the bulk of new infections, budgets, programmes, policies and human resource commitments do not reflect this. Many interventions continue to be aimed at an imaginary boy or man or a fictional gender-neutral public."[17] Given this analysis by the Task Force, the review looked at a small but important set of indicators in an attempt to analyze the extent to which plans, budgets, programmes, policies and human resources have been put in place since the Task Force report of 2004 to ensure that national HIV programmes are more gender-responsive. In this regard, the follow indicators were used as proxies for assessing progress:

    - **National Action Plans on women, girls and HIV have been developed.** The Task Force called for the development of national Action Plans on women, girls and HIV, and the existence of such a Plan, developed by national stakeholders, is one indicator of political commitment and intent. The review examined whether countries developed national Action Plans on women, girls and HIV and whether these Plans had been costed and funded. The process of developing a national Action Plan was seen as an important element of the review, as the Task Force report noted that there "was lack of communication between the bodies tasked with coordinating the gender response and those coordinating the HIV/AIDS response."[18] The capacity and willingness of countries to bring together a range

[14] OSISA is a southern African advocacy foundation that operates through networking, facilitation, grant-making and capacity-building in ten countries in Southern Africa: Angola, Botswana, Democratic Republic of Congo, Lesotho, Namibia, Malawi, Mozambique, Swaziland, Zambia and Zimbabwe. OSISA's HIV/AIDS programme monitor's HIV/AIDS policy and law-making processes as well as public expenditure of AIDS funds, and works with a large portfolio of organisations in each of the SGTF countries to amplify the voices of communities marginalised by the epidemic, with a strong emphasis on gender and women's rights.
[15] For members of this team, see UNAIDS/PCB(20)/07.11, 27 April 2007 prepared for the 20th meeting of the UNAIDS Programme Coordinating Board.
[16] In the time frame allowed, it was not possible to visit Namibia, Zambia and Zimbabwe; thus, the information contained in this report is based on desk reviews of documents and telephone interviews.
[17] See "Facing the Future Together, Report of the United Nations Secretary-General's Task Force on Women, girls and HIV/AIDS in Southern Africa", 2004. http://womenandaids.unaids.org/regional/docs/Report%20of%20SG%27s%20Task%20Force.pdf, p.6.
[18] Ibid, p.15.

of stakeholders to develop, finalise, cost and fundraise for these Action Plans was used in this review as a proxy for an indication of a first step in advancing work on women and HIV.

- **Gender and HIV programmes have been implemented.** An additional indicator involved the extent to which countries have moved beyond the development of national Action Plans on women, girls and HIV towards the actual implementation of programmes that seek to address the gender-based vulnerabilities of women and/or men to HIV, especially in relation to prevention. This was seen as an important indicator of whether Action Plans have been implemented at country and community level. From key informant interviews and an internet search, this indicator compiled information on gender-related HIV prevention programmes implemented at country level since 2004.
- **Gender and HIV programmes have received increased funding.** Another indicator that was used in the review focussed on financial resources. The Secretary General's Task Force report noted that "because changes in gender relations occur slowly, not enough funding or attention is given to programmes that try to address the deeper connections between gender and HIV/AIDS."[19] In seeking to assess progress in addressing this Task Force concern, the review attempted to look at whether countries have mobilised internal and external financial resources to fund programmes that respond in a gender-sensitive manner to the prevention, care and support and treatment needs of women/girls and men/boys.
- **There are additional skills and technical capacities on gender and HIV in country.** The review also examined whether countries have put in place the human resource capacities needed to develop and implement HIV programmes that address men's and women's different needs, as well as the vulnerability to HIV that is related to gender inequality. Here the review chose to analyze the existence and funding of human resource expertise in gender and HIV as a proxy for commitment and ability to advance gender and HIV responses.
- **Gender and HIV research has been carried out.** Another important area of interest for the Task Force was research. The Task Force report noted a number of areas that required rigorous research in order to truly understand the dynamics of the national epidemic, and in particular the dynamics behind the persistently high HIV infection rates in women and girls, and effective programming interventions to address these trends. These included: violence against women, girls access to education, the provision of home-based care, and a range of other issues.[20] The review therefore examined whether countries conducted research on the intersections between gender equality and HIV. Given the time constraints, the review looked preliminarily at how many countries have undertaken research to better understand the links between violence against women and HIV. This area was chosen given the high rates of intimate partner and sexual violence in many of the countries in Southern Africa.

Challenges and limitations of the review

15. Given the short-time frame, including limited time in countries, the review provides only a snap shot of progress in the areas examined. Furthermore, one of the biggest stumbling blocks to collecting information for the review was the lack of a clear monitoring and evaluation framework and a locus of accountability for follow up to the Task Force recommendations. The lack of an monitoring and evaluation mechanism

[19] Ibid, p. 6.
[20] See "Facing the Future Together, Report of the United Nations Secretary-General's Task Force on Women, girls and HIV/AIDS in Southern Africa", 2004. http://womenandaids.unaids.org/regional/docs/Report%20of%20SG%27s%20Task%20Force.pdf, pp. 11, 25, 34, 39.

and a government-owned institutional 'home' for Task Force or gender-related activities made it difficult to point out where systems and processes may have failed to deliver on key recommendations. In some countries the 'memory' regarding Task Force work was embedded in the UN system; in other places, it was within government; and in a few places, civil society organisations continue to champion the issues in the Task Force report.

16. Finally, it must be noted that the AIDS environment in many southern African countries has changed dramatically since 2003. The Global Fund for AIDS, Tuberculosis and Malaria, the World Bank, the United Kingdom's Department for International Development, the United States President's Emergency Program for AIDS Relief, among others, have introduced considerable resources into the region. Governments have also streamlined HIV programme management and coordination in line with what are known as the "Three Ones" principles: One national AIDS action framework, One national AIDS coordinating body, and One national AIDS monitoring and evaluation system. Furthermore, at the political level, the commitment to greatly expand AIDS efforts has grown, with calls for Universal Access to HIV prevention, treatment, care and support, overtaking earlier concerns about whether southern African countries had the systems and capacities to expand their programmes. These changes have had an impact on the application of some of the recommendations of the Task Force. In particular, they have underlined the critical importance of integrating gender issues into all major national HIV processes - from planning, and budgeting to implementation to monitoring and evaluation - in order to ensure that gender issues are seriously addressed in national HIV programmes. Notwithstanding these caveats, the review process revealed rich information and insights that were based on the fact that the Task Force did indeed lay the groundwork for setting an agenda for moving ahead on gender and HIV action in national responses.

NATIONAL ACTION PLANS ON WOMEN, GIRLS AND HIV

17. Most of the countries which participated in the Task Force process developed national reports on women, girls and HIV. Based on these reports, seven Task Force countries developed Action Plans on women, girls and HIV. The exceptions of South Africa and Namibia. National task forces were established to oversee the implementation of the Action Plans. In most cases, these Action Plans were costed, and in some instances they were funded. **Table 1** below outlines the results of this process at the time of writing this report.

18. These Action Plans included a range of activities aimed at improving HIV prevention for women and girls and mitigating the impact of AIDS on them. It should be noted, however, that many of these plans were largely stand-alone plans that were separate from national AIDS planning processes. Key informants indicated that, although these plans have informed the activities of government, civil society and the UN, they have often remained outside the "mainstream" AIDS processes and programming.

19. In Botswana, the UN system took responsibility for coordinating and supporting the work of the Task Force, and ensuring that its recommendations were frequently referenced in the speeches and statements of various UN officials and members of Government. Similarly, in Zimbabwe, a well-balanced team from within the UN family spearheaded the national action planning process on women and girls with strong participation from civil society organisations.

Table 1: National Gender and HIV Action Plans

Country	National Action Plan on women, girls and HIV developed	National Action Plan Action Plan on women, girls and HIV costed	National Action Plan on women, girls and HIV funded
Botswana	Yes	Yes	Partially
Lesotho	Yes	Yes	No
Namibia	No	n/a	n/a
Malawi	Yes	Yes	Partially
Mozambique	Yes	Yes	Partially
South Africa	No[21]	n/a	n/a
Swaziland	Yes	No	No
Zambia	Yes[22]	Yes	No
Zimbabwe	Yes[23]	Yes	No[24]

20. In Malawi, the Action Plan advanced the furthest in respect of integration of gender into the national HIV planning process. The review indicates that this may be attributed to two things. First, the two Task Force members in Malawi were prominent – one being a parliamentarian and former Vice President of the country with a known track record on HIV, and the other being a senior gender researcher with access to important networks within the donor community. Their collaboration with the UN, as part of the Task Force process, helped ensure that the actors within the national HIV response took the recommendations of the Task Force seriously, which in turn led to the integration of gender issues in national HIV planning processes. In addition, since the country has embraced the basket-funding approach, these issues were included in the common basket for donors. Another reason why the Action Plan moved forward in Malawi may be linked to the initiation of the Development Partners Joint Program on Gender Equality and Women, and the drafting of the United Nations Development Assistance Framework for Malawi (2008-2011). These processes have complemented the Government's efforts to harmonise and mainstream gender in national HIV response planning.

21. The lesson learned from Malawi therefore is that a common basket approach can help to secure funding for gender and HIV issues if the country has included these issues in the basket. However, it is also important to note that, where there is insufficient political will within government to include gender-related programmes in the national response, the basket funding approach may result in virtually no funding for gender-related programmes. This underscores the need for sound advocacy strategies, backed by evidence and solid technical assistance, to ensure that, as the Three Ones are engendered, countries are encouraged and assisted to follow through on delivering well-developed strategies and programmes on gender and HIV.

22. In Mozambique, the Action Plan that was developed out of the Task Force process was another example of success. The Action Plan found early support from the

[21] It must be noted, however, that the new National Strategic Plan of South Africa, approved by the Cabinet in March 2007, includes programmes and campaigns aimed at promoting gender equality, reducing new infections amongst women and girls and providing services.
[22] A Strategic Plan on Gender (2004 – 2008) was developed with the aim of operationalising the national Gender Policy (2000) which had been in place since before the Task Force was established. The Task Force process in Zambia was used to reinforce the strategic plan. Mechanisms had already bene put in place at national level to ensure coordination and implementation of the Plan. Thee NAP on women and girls which falls into the Strategic Plan has been drafted but has yet to be finalised. Some costing of activities has now taken places as part of Zambia's proposal for the Round 7 cycle of the Global Fund to Fight AIDS, TB and Malaria.
[23] Although the Plan has been completed, it has not been officially launched by the Ministry. At the time of data collection, it was anticipated that the launch would take place in the next few months.

Flemish government, which agreed to support a $12.8 million proposal to “focus on areas of intervention identified by the U.N. Secretary General's Task Force on Women, Girls and AIDS in Southern Africa, including education, prevention strategies, violence prevention, inheritance and property rights, the role of women as caregivers, and care and treatment for HIV-positive women.” UNFPA was the implementing agency for the programme which was described by the Flemish government as "one answer to the growing feminization of the HIV and AIDS epidemic." [25]

23. The availability of funding to support at least some activities in the Plan was an important factor in fast-tracking the development of HIV programmes for women and girls in the country. The funds were used to support activities in 2005 that focussed on promoting women’s property and inheritance rights, addressing gender-based violence, the feminization of the epidemic, and the specific vulnerability of women to HIV. The funds were also used for an assessment of the proportion of resources for the HIV response allocated to issues related to women, development of training for Gender and HIV focal points in the Ministry of Gender, and a national action-planning workshop involving all key stakeholders.[26] The UN system went on to develop a budget of $23.5 million to top up the support received from the Flemish Government, as part of the UN Joint Programme on Women’s Empowerment and Gender Equality. While only a small portion of these funds have actually been raised, the model is an important one that demonstrates the ways in which the UN can work together to tackle cross-cutting issues like gender. It also demonstrates that in some cases discrete, direct funding is an important factor linked to the expansion of gender-related HIV activities. Without ensuring a solid link to national AIDS programming processes, however, such funding does not necessarily lead to sustained and integrated gender programmes that become an integral part of the national AIDS response.

24. South Africa, as the most populous country in the region, with the most financial and technical resources, and one of the most sophisticated constitutional, policy and civil society environments in the world, is somewhat of an outlier in the Task Force process which did not have traction in the country. The two Task Force members were both from civil society, and there were no clear links with relevant Ministries that would be able to ensure national ownership. Nevertheless, in March 2007, the country developed its second National Strategic Plan on HIV and AIDS, and reconfigured the National AIDS Council and its provincial structures. The Cabinet of the country agreed to fund the Strategic Plan to the value of R44 billion (approximately 6.2 billion USD). This commitment includes a significant number of programmes and campaigns aimed at promoting gender equality, reducing new infections amongst women and girls, and providing services for them. This progress, however, cannot be linked to the Task Force process in South Africa.

25. In Swaziland, the development and costing of the Action Plan was a long process that was hampered by severe capacity constraints in the Gender Unit in the Ministry of Home Affairs, which was the government lead agency for follow up to the Task Force recommendations. The Gender Unit runs on a budget of less than $50 000 a year, which primarily pays for the salaries of its two staff members. The Unit’s capacity deficit was compounded by the fact that the women’s rights organisation mandated to support the Unit – the International Community of Women Living with HIV and AIDS - also lacked sufficient capacity to take the process forward. However, with a new constitution in place as of February 2006, in which women’s rights are now enshrined, there is renewed hope in the country that the recommendations of the Task Force will find support. In addition, a coalition of women’s rights organisations has recently been

[25] 2005. “Mozambique Partners with U.N., Flemish Government to Launch Program Addressing HIV/AIDS among Women” See http://www.medicalnewstoday.com/medicalnews.php?newsid=24240
[26] Draft Annual Plan 2005: Technical Working Group on Gender (Mozambique).

formed to facilitate the process of engendering Swaziland's process of developing a proposal for Round 7 of the Global Fund. If successful, the proposal could see the injection of $15 million over the next five years to support activities that were recommended in the National Action Plan on women and girls that was developed as a consequence of the Task Force.

26. In Zambia, national consultations on gender equality began in the late 1990s. These involved representatives from Government, civil society, and faith-based organizations and were led by the Gender in Development Division in the Office of the Cabinet. The Gender in Development Division was mandated to convene the sectors; guide the technical planning, monitoring and implementation of the gender policy development and legislative review; coordinate the response; and report to the Cabinet and Office of the President on progress. The national gender policy was launched in 2000 and formalizes principles to guide the implementation by all partners and the coordination framework at sub-national level. The Strategic Plan of Action on gender, generally covering all the areas in the Task Force report, was developed to operationalise the gender policy and was linked to the National Development Plan and Poverty Reduction Strategy Paper to ensure it would be resourced through sector budgets and monitored through existing mechanisms.

27. Given the significant variations in policy environments, and cultural contexts in each country, there were different approaches to developing and operationalizing the national Action Plans on women, girls and HIV. Countries which have seen some gains have benefited from various systems of support. These included: (a) the existence of funds either pledged directly (as in the case of Mozambique) or available in the environment (as in the case of Malawi and South Africa); (b) UN system support as in the case of Botswana, Malawi, Mozambique and Zimbabwe; (c) government support through multisectoral and/or high level engagement, such as in Zambia and (d) well-respected champions, as is the case in Malawi. Countries, such as Botswana and Namibia, which are both struggling to access donor funding for a range of issues due to their middle and lower-middle income status respectively, found it more difficult to access big pots of money, and indeed, in the case of Namibia, struggled to even get the Task Force recommendations off the ground. For Swaziland and Lesotho, progress was hampered by the fact that responsibility for follow-up was placed outside the Government. While civil society actors are crucial partners in respect of the integration of gender equality initiatives within national HIV programmes, the ultimate responsibility for the promotion and protection of women's rights, and for service delivery rests with the State.

GENDER AND HIV PROGRAMMING

28. The need for concrete programmes to address gender inequality and provide HIV services to women and girls was a major concern of the Task Force. The Task Force report pointed out that promoting girls' education, stopping intergenerational sex, bolstering women's economic status, and preventing gender-based violence were critical to decreasing the vulnerability of women and girls to HIV infection. The report noted that while women tend to have better access to health services than men – typically during pregnancy and as a result of bearing responsibility for the care of children – young women often face socio-economic challenges that undermine their ability to act on the knowledge they have about preventing HIV transmission.[27]

29. The review looked at gender-related HIV programmes that were either funded as a direct result of the Task Force process (which was only the case in Mozambique) or

[27] See "Facing the Future Together, Report of the United Nations Secretary-General's Task Force on Women, girls and HIV/AIDS in Southern Africa", 2004. http://womenandaids.unaids.org/regional/docs/Report%20of%20SG%27s%20Task%20Force.pdf, p. 20-21.

otherwise found funding during the 2004 - 2007 timeframe. This was an attempt to catalogue some of the gender-related changes that have followed the Task Force's advocacy initiatives, while acknowledging that not all gender action can be attributed to the Task Force. The review focused on HIV prevention programmes because country-level interviews revealed that prevention is a significant area of concern for key informants. Thus, the review examined the existence of programmes that specifically aim to reduce the gender-based vulnerability of women and men to HIV and that were listed within national Action Plans and/or in the regional report issued by the Task Force. These included the following:

- Programmes[28] seeking to reduce gender-based violence in the context of HIV
- Programmes seeking to transform gender roles in the context of HIV (e.g. Stepping Stones)
- Programmes seeking to promote sexuality education in the context of HIV
- Programmes seeking to discourage intergenerational sex
- Programmes seeking to improve life skills and safer sex negotiation skills amongst girls.

30. The review reveals that there has been slow progress in developing and implementing programmes that directly address gender-based risks and vulnerabilities to HIV infection. Instead, there has been a continued focus on advocacy and policy-level workshops, without commensurate attention to the development of national and community-level gender and HIV programmes.

31. The review found that all countries have had at least one national-level policy workshop on gender and AIDS since 2004, many of which involved senior public servants or politicians. For example, since 2005, the International Community of Women Living with HIV and AIDS has held a series of policy workshops in Southern Africa. These have included information on the linkages between gender and HIV for parliamentarians, government officials and non-governmental organizations in Lesotho, Namibia, Swaziland, South Africa, Zambia, Malawi and Mozambique. These workshops have included Young Women's Dialogues held in Windhoek, Namibia and in Durban, South Africa. Furthermore, the Parliamentarians for Women's Health Project – a three-year initiative funded by the Bill & Melinda Gates Foundation – is on-going in Botswana and Namibia.

32. While policy and advocacy efforts are important, they have dominated action in this vital area and have not necessarily been matched by programmatic responses on the ground. In the last three years, only four out of nine countries have piloted gender and HIV programmes related to HIV prevention in any manner that can be documented; and even fewer have expanded these programmes beyond a single district or community. This does not of course mean that such programmes do not exist at project level in each country reviewed. However, it does mean that these are not being sufficiently replicated or expanded to cover a significant population base.

33. Despite this, there are some notable small-scale projects that have been highlighted by the review. In Malawi, the effectiveness of a Save the Children programme designed to reduce girls' participation in intergenerational sexual relationships has been well documented. That programme works with girls to develop skills to decline advances from older men through the use of community structures and lessons in self-esteem. In South Africa, the *Intervention with Microfinance for AIDS & Gender*

[28] For the purposes of this review, a "programme" is defined as a series of activities that is sustained by one institution in a given community for over a one-year period. This definition does not include medical interventions such as post-exposure prophylaxis and prevention of mother to child transmission because these are offered as services, and typically do not involve a behaviour-change component.

Equity (IMAGE) project in the province of Limpopo is an example of a programmatic model that is based on action research. The study is described as "a research initiative that seeks to evaluate the potential role of a microfinance-based poverty alleviation and empowerment strategy in behaviour change and the prevention of HIV and gender based violence."[29] The intervention combines a micro-lending scheme with a two phase Participatory Learning and Action Curriculum for loan recipients called *Sisters for Life*. The study is "an integrated, prospective, randomized, matched community intervention trial that seeks to thoroughly examine the impact of this social intervention that addresses poverty and gender-based inequalities on social, behavioural and biological outcomes - including HIV incidence." The intervention seeks to address both social norms and the nature of the individual marriages/partnerships of the women who participate in order to influence sexual behaviour and reduce women's experiences of gender-based violence. Initial results indicate that, for participants in the study, self-reported intimate partner violence has decreased by 55% - an impressive level of effectiveness.[30] More modest impact has been noted on HIV risk behaviours, and data on HIV incidence is still being analysed.

34. In Mozambique, the Government, with the support of the Canadian International Development Agency, undertook a joint project on gender and HIV, highlighting a model for HIV prevention, care and support that was based on community involvement in the transformation of gender norms, improved literacy and income generation.

35. In Zambia, the Strategic Plan on Gender clearly outlines national expansion actions for gender responses in all sectors. Prevention-related priorities include a rural literacy programme for girls; vocational skills programmes for out of school youth, with an emphasis on girls; community awareness campaigns on the effects of gender-based violence; the strengthening of legal mechanisms for responding to gender-based violence; and the engagement of traditional leaders in creating awareness and enforcing corrective measures to stop harmful practices, such as sexual cleansing and widow inheritance. The National Plan of Action for Women, Girls and HIV builds on this plan, and although the National Plan has yet to be finalized officially, the UNAIDS country office notes that some of these activities are already underway and being monitored.

36. In Zimbabwe, the Women and AIDS Support Network – a Harare-based NGO - runs a training and information, education and communication programme on gender and HIV which provides women-friendly materials and information on the risks and vulnerabilities of HIV infection. The Women and AIDS Support Network also offers gender-mainstreaming workshops to AIDS service organisations wishing to improve their capacity to programme in a gender-sensitive manner. This is an interesting model that seeks to encourage scale-up. However, as a non-governmental organisation, the Women and AIDS Support Network struggles to access continuous funding to ensure that all areas of the country are adequately covered.

37. South Africa is the only country where gender-related prevention programmes can be said to have been meaningfully taken to scale. The *Soul City* and *Love Life* programmes have both integrated gender messaging and outcomes into their programme frameworks. These represent major initiatives that have received Government, donor and private sector investment, and which operate on a national basis. At its height, the *Love Life* programme received over R200 million (US$ 28

[29] Paul M Pronyk, James R Hargreaves, Julia C Kim, Linda A Morison, Godfrey Phetla, Charlotte Watts, Joanna Busza, John D H Porter, "Effect of a structural intervention for the prevention of intimate-partner violence and HIV in rural South Africa: a cluster randomized trial", Lancet 368, 1973-1983, 2006.
[30] Ibid.

million) per annum in funding from a variety of sources, while *Soul City's* programme budget within South Africa is approximately US$ 15 million, with an additional US$ 34 million for its regional work in Botswana, Lesotho, Malawi, Mozambique, Swaziland, Namibia, Zambia and Zimbabwe.[31]

38. Another interesting finding of the review was the fact that there has also been an increase in the number of programmes that address male involvement in gender and HIV activities. These are a welcome addition to the AIDS response. Interestingly, in South Africa these have begun to be taken to scale. The Government has adopted male involvement structures in a number of provinces, and is supporting community activities in which men's attitudes and behaviours related to sex are the explicit target of interventions. The *Men As Partners* programme and the newly formed Sonke Gender Justice Network have developed much of this work. Engender Health's *Men As Partners* Programme provides education and training of young men to reduce gender-based violence, reduce the risk of HIV infection and improve the attitudes of men and boys towards gender equality and to women and girls in general. This programme has been scaled up in Botswana and Swaziland through theatre programmes aimed at reaching out to young men with messages about gender transformation. The Sonke Gender Justice Network has a focus on young men, working at community level to "challenge existing gender stereotypes and reversing the HIV epidemic."[32]

39. Other noteworthy initiatives that focus on men, gender and AIDS include Women For Change, which is a Zambian non-governmental organization that explicitly focuses on traditional leadership structures, and on changing the attitudes of men in senior leadership positions towards women and girls especially in the context of AIDS, and PADARE, which is the Zimbabwean men's forum. While PADARE has an emphasis on involving men in home-based care, the organisation also works to change men's behaviours and attitudes towards women to enable them to negotiate safer sex behaviours with their partners.

40. The review shows that each country has one or more successful gender-related HIV activity, but that programmes addressing gender-based risks and vulnerabilities to HIV have remained largely at project level. Many of these projects have been once-off, and have existed outside the national AIDS planning and implementation framework. The challenge here is not simply about funding. The primary concern uncovered by the review is related to the fact that, where these projects are developing innovative approaches, there is little scope for sharing and expanding these initiatives because they fall outside the mainstream AIDS response. Similarly, these projects could learn from the experiences of others in order to enhance and improve how they work, but again, are not afforded this opportunity because of their somewhat "marginal" status.

41. In terms of a significant, scaled up expansion of gender and prevention-related programming, South Africa is the most advanced country amongst those reviewed. This requires some examination. The review found that the legal and policy environment in respect of women's rights is more supportive in South Africa than it is elsewhere, in large part because of the constitutional protections enjoyed by women, and because of the commitments to gender equality demonstrated at all levels of leadership in the country, from the Parliament to the Executive and the Courts. The country also has a significant history of organised women's activism and leadership and therefore strong capacities to develop gender-related HIV programmes within the

[31] eAfrica "Soul City: A Strategy for Small-Screen Education" October 2005. http://www.saiia.org.za/modules.php?op=modload&name=News&file=article&sid=724
[32] http://www.genderjustice.org.za/programmes/programmes.html#omc

State and civil society. This has translated into well-designed programmes that – given South Africa's domestic resources – can be supported and rolled out nationally. In addition, as a number of key informants noted in interviews, given the difficulties that South African women face in respect of gender inequality and gender-based violence, it is appropriate that the country should have developed and funded its own remedies.

FUNDING OF GENDER-RELATED HIV PROGRAMMES

42. The recommendations of the Task Force to donors and development partners on funding referred to increasing financial assistance to women's and men's organizations addressing HIV and gender-based violence by at least 25 per cent from 2003 levels. The Task Force further recommended that "a minimum of 50 per cent of the resources programmed under the Global Fund to fight AIDS, Tuberculosis and Malaria; World Bank Multi-Country HIV/AIDS Programme, WHO's 3 by 5 initiative and other initiatives" be directed at women and girls.[33] Quantifying gender commitments within donor and national AIDS budgets is a difficult task. Indeed, over the last few years a number of attempts have been made to do this at global and regional level with varying results.

43. In country visits and in the literature review, it was noted that funding patterns have shifted dramatically in the last five years. Indeed, as a recent report by OSISA and CADRE notes, "The principles of aid effectiveness outlined in the Paris Declaration require changes in the way development assistance is administered. If 'traditional' development assistance involved a multitude of individual development projects, funded and administered directly by a range of institutions, and not linked systematically into an overall development plan, 'new aid modalities' emphasise a much more streamlined approach to delivering aid which utilises country systems and structures and gives national governments much greater control over the way aid is used." As a result, the report notes that within the AIDS sector, "The Three Ones have become a powerful rhetorical force in the way that AIDS response strategies are framed and understood both internationally and at country level." [34]

44. While governments have hailed budget support and sector-wide approaches, there is no denying that they are being implemented with little attention to parallel efforts to develop gender budgeting strategies. As a result, it is extremely difficult to track expenditure on AIDS programmes by gender, and therefore it is hard to measure progress.

45. The Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) has become an integral part of national level AIDS responses. Global Fund requirements are non-prescriptive and the Fund exists to support country-driven demands. Its transparent processes and the ease of access to information relating to its grants have been lauded by many stakeholders, and make it relatively simple to access information about proposals and grants. Countries applying for Global Fund monies set their own priorities for programming, and grants tend to reflect not only what the Global Fund deems to be technically sound, but also what countries consider to be priorities.

46. Ostensibly, if countries request funds for gender-related HIV activities, and their overall proposals are technically sound and are approved, they will receive funds to support these requests. Yet, a desk review of Global Fund grants made in rounds 1 – 5 indicated that only half of the grants received by the eight countries in which Global

[33] See *Facing the Future Together, Report of the United Nations Secretary-General's Task Force on Women, Girls and HIV/AIDS in Southern Africa*, 2004

[34] 2007. CADRE/OSISA. Pioneers, Partners, Providers: The Dynamics of Civil society and AIDS Funding in Southern Africa. (forthcoming)

Fund data could be obtained (all Task Force countries except Botswana) include any *explicit* reference to gender. While these grants may cover some activities that address gender issues, it does not appear that country proposals are in fact asking for funding of gender-related HIV programmes to a significant degree. Nor does it appear that there is explicit attention paid to systematically tracking how gender issues are being addressed within grants.[35] Given the dynamics of the HIV epidemic in the region, with alarming rates of infection in young women, the absence of gender-related programmes in funding applications, or the tracking of such programmes, is a very concerning gap that needs to be addressed.

47. Indeed, neither governments, donors nor the UN system have yet to define what constitutes "gender-related HIV programming", nor have they attempted to "gender-disaggregate" their HIV programme spending. Studies to track expenditure on HIV by gender are usually conducted by non-governmental organizations or independent institutions that often have to develop complex processes for extracting such information. The review found that, at the very least, developing methods for tracking resources on HIV in a manner that demonstrates financial commitments to the promotion of gender equality and equity in national HIV responses remains an important step that has not yet been taken.

48. In addition to the Global Fund, there are a number of other significant funders and interesting initiatives that are beginning to show results for gender and HIV funding. In Malawi and Mozambique, several donors are actively funding gender and HIV programmes and there is commitment to coordination and harmonisation. As countries move towards the adoption of various aspects of the Paris Declaration on Aid Effectiveness, these models of collaboration towards the achievement of mutually agreed objectives will become increasingly important.

49. In Malawi, there have been significant moves to programme and fund gender and HIV interventions. Recent initiatives, such as the Development Partners Joint Program on Gender Equality and Women and the United Nations Development Assistance Framework for Malawi (2008-2011), have complemented the Government's efforts to harmonise and mainstream gender in national HIV response planning. Given the firm foundation that has been built, the next five years in Malawi will be the test of the country's ability to expand work to address the gender-based drivers of the epidemic.

50. In Mozambique, an organised and well-coordinated strategy has been devised for funding the gender and HIV response, building on the Task Force recommendations. The Gender Coordination Group provides a mechanism for the exchange of information and support for gender equality amongst Government, development partners, and civil society groups. The Gender Coordination Group evolved from the former Gender Donor Group (UN agencies, bilateral and multilateral donors) and expanded to include all partners. In 2005, the Gender Coordination Group advocated for routine reporting on gender issues from all sectors. It is currently reviewing its Terms of Reference with the aim of placing greater emphasis on coordination and "promotion of synergies" rather than the exchange of information only.

51. Furthermore, as indicated earlier, the Flemish government provided significant funding to kick start the process of national action planning related to women, girls and HIV in Mozambique. This project, which is still underway, influenced the development of the *Joint Programme on Women's Empowerment and Gender*

[35] See also a recent report by Action Aid which notes, "While CCMs (country coordinating mechanisms) are urged to ensure gender-balanced representation and to incorporate a gender analysis into their plans, they are not required to translate these into measurable outcomes, aside from collecting sex-disaggregated data." From *Show us the money: Is gender-based violence on the donor agenda?* Action Aid/ Women Won't Wait Campaign, 2006.

Equality, an initiative budgeted at $23.5 million, under the current UNDAF (2007 – 2009), with the aim of building upon the support provided by the Flemish Government and continuing to expand the work inspired by the Task Force.

52. This analysis highlights the importance of creating and agreeing upon common methodologies to fund, and track funding, for gender-related HIV programmes. It also highlights the importance of improving capacity and performance on both sides of the equation. First, governments and civil society must believe there is a need for gender-related programmes in HIV responses and build capacity to seek such funding, absorb it and translate it into gender-related HIV programmes. Secondly, donors must also prioritize funding for programmes that address the gender-related vulnerabilities to HIV for both men and women. Their recognition of the importance of gender should be reflected in their criteria for awarding grants and directing funding, which may necessitate a review of their own gender capacities. Thirdly, as assistance becomes more harmonized and aligned, modalities must be found that encourage and enable governments, donors and civil society to agree on the level funding needed for gender-related HIV programmes and on their content.

GENDER CAPACITY AND EXPERTISE

53. In its report, the Task Force highlighted the need for greater gender expertise and capacity at country level. It stated that "not enough people know how to 'do gender' – in other words, how to conduct a thorough gender analysis of the situation and design responses tailored to the different requirements of men, women, boys and girls. There is an urgent need to make the language of gender more practical and accessible to people at the community and programme levels."[36] The Task Force also emphasised the importance of supporting and strengthening local women's groups and organisations. Since the Task Force released its report, concern about the lack of gender expertise in many countries has continued.

54. The review looked at the various stakeholders in terms of their ability to provide the kind of guidance and technical support required if countries are to engender the Three Ones and expand their work on making HIV programmes gender-responsive. In many countries the lack of expertise in gender and HIV analysis, planning, research and programming remains a critical challenge three years after the Task Force process ended. The review sought to understand what is taking place at country level in terms of: (a) coordination on gender and HIV issues, and (b) technical capacity to undertake planning and programming in the second instance.

55. In terms of coordination on gender and HIV, the review indicated that the UN system has not done enough. In five out of the nine countries, (Botswana, Namibia, Malawi, South Africa and Zambia), no operational theme group on gender exists.[37] In Lesotho, Mozambique, Swaziland and Zimbabwe, gender theme groups are operational, and in Malawi, various UN agencies participate in the Development Assistance Group on Gender which brings together a range of stakeholders to network and share information on gender issues at national level.

56. In terms of staff capacity to address gender and HIV issues in an integrated manner, the UN also requires strengthening. In Botswana, Zambia and Zimbabwe, there are designated members of staff who have gender and HIV as key components of their job descriptions (focal points). In Zimbabwe, the staff member is a full-time Gender

[36] See "Facing the Future Together, Report of the United Nations Secretary-General's Task Force on Women, girls and HIV/AIDS in Southern Africa", 2004. http://womenandaids.unaids.org/regional/docs/Report%20of%20SG%27s%20Task%20Force.pdf, p. 6

[37] The definition of "operational" in this instance means that the Theme Group has had at least one meeting in the last six months. Information used in this section of the report was obtained from country visits and the UNDG website (www.undg.org/countrydatabase).

Officer within UNAIDS. However, in Lesotho, Namibia and South Africa, no gender and HIV focal points have been designated. A member of the UN Country Team in Namibia indicated that, while there is a strong desire to promote gender issues and to follow up on the Task Force process, the UN Country Team lacks technical capacity and skills on gender and HIV. This was echoed in South Africa where interviews with members of the UN Country Team indicated that gender capacity within the UN team is weak, although there is significant interest in boosting this capacity. There was also considerable interest in the creation of gender focal points that could work with the Joint UN Teams on AIDS that are being established in many UN offices in the region.

57. Despite the lack of designated HIV and gender focal points in these countries, it is worth noting that in a number of agencies there are gender focal points that deal with a range of other issues from sustainable development to food security. Harnessing their skills and ensuring that they are "HIV competent" would be an important step towards enhancing the ability of the UN system to respond to the gendered dynamics of the HIV epidemic.

58. Very few governments in the countries reviewed have the capacity at present within their Ministries of Gender and Women's Affairs to plan, programme and fund integrated initiatives that seek to address gender inequality in the context of HIV. In Botswana, there is no focal point within Women's Affairs Department on HIV or sexual or reproductive health, and the post of Gender Officer within the National AIDS Coordinating Authority is vacant. Similarly, in Lesotho, a post has not been created within the Ministry of Gender, Youth, Sports and Recreation to address HIV. In Namibia, within the Ministry of Gender Equality and Child Welfare, a small committee oversees the Ministry's workplace HIV policy. This group also provides some support for HIV mainstreaming in the programmes of the Ministry. However, informants within civil society note that this unit requires significant support in order to be operational.

59. In South Africa, within the Ministry of Health, there is a Director responsible for Women's Health, who works closely with the South African National AIDS Council. The newly constituted Council also includes sector representatives, including representation from what is called the "women's sector." In Swaziland, the Gender Unit, which is located in the Ministry of Home Affairs, has only two employees. Neither of these staff members has expertise in sexual and reproductive health or HIV. In Zimbabwe, the Ministry of Youth, Women's Affairs, Child Welfare and Community Development also has a focal point who is responsible for HIV, which the National AIDS council employs an officer responsible for Gender and Youth.

60. In most countries there is some capacity within civil society sector to undertake gender analysis and programming on HIV and gender. In many cases, there are academic institutions, individual consultants, and research institutions that have excellent skills that could be better utilised by government and the UN system. For example, Women in Law in Southern Africa is the lead non-governmental organization working on gender and HIV issues in Lesotho, and has been the secretariat for Task Force activities in the country. The Women in Law in Southern Africa (Malawi) has also played an important role in developing research and analysis. Furthermore, there are a few prominent researchers, who regularly consult for international agencies. In Mozambique, Forum Mulher, a network of non-governmental organizations working on women's empowerment, provides gender expertise, though capacity for gender and HIV is admittedly weaker. The Community Development Foundation, the foundation created by Ms Graca Machel, former Minister of Education, is another notable non-governmental organization in the country, providing a strong focus on empowering girls and women in the context of the fight against HIV.

61. In Namibia, The Legal Assistance Centre, the Namibian Women's Leadership Centre and Sister Namibia have played a leading role in promoting sexual and reproductive rights and the rights of people living with HIV. The establishment of a section of the International Community of Women Living with HIV and AIDS in 2005 in Namibia has also bolstered the capacity of non-governmental organizations in Namibia to respond to the gendered nature of the epidemic.

62. In South Africa, the existence of large networks of tertiary educational institutions, a handful of which have under-graduate and graduate level courses on gender, means that there is capacity on gender that is also often used by other countries in the region. In addition, South Africa has one of the largest non-governmental sectors in the world, with a number of women's rights activists, many of whom are professionally trained in fields such as gender and the law, policy, medicine, and other social sciences. In Swaziland, Women in Law in Southern Africa has played a key role in research and policy and legislative matters; and Swaziland Positive Living has increasingly worked on issues of property and inheritance rights and the sexual and reproductive health and rights of women living with HIV.

63. Like the other countries, Zambia has a plethora of gender groups that are well equipped to address HIV issues. These include Women in Law in Southern Africa (Zambia), Women for Change, Society for Women and AIDS in Africa, as well as a range of international non-governmental organizations. Like South Africa, Zimbabwe has a rich history of women's rights activism that has translated into a strong non-governmental gender sector. In recent years as many professionals have left, capacity has significantly diminished. However, there remain organisations such as Women in Law in Southern Africa, the Women and AIDS Support Network, SAFAIDS, Musasa Project and a range of others.

64. In summary, preliminary evidence from the review indicates that, while the capacity of governments and the UN system to conduct gender analysis and implement programmes on gender and HIV is weak, in most countries considerable capacity exists in civil society. Both government and the UN must be encouraged to train key staff on gender and HIV programming, appoint dedicated gender and HIV staff or focal points, bring together relevant actors on gender and HIV, and utilise the skills and experiences of civil society experts to influence HIV planning and implementation processes.

RESEARCH ON VIOLENCE AGAINST WOMEN AND HIV

65. The Task Force identified a wide range of issues that required further research, from operational research related to flexible schooling options for girls engaged in home-based care, to more research on trends and dynamics of intergenerational sex, to investigations into conducting "research into the costs and feasibility of establishing counseling 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."[38]

66. Given the wide scope of research options recommended by the Task Force, the review team felt it would be important to narrow its focus in order to make the exercise more manageable. One of the focus areas of the Task Force was violence against women and girls, with the Task Force citing domestic violence, marital rape, and sexual violence as critical drivers of HIV transmission.[39] In its report, the Task Force stated, "We must protect girls and women from the direct and long-term risks of HIV

[38] See "Facing the Future Together, Report of the United Nations Secretary-General's Task Force on Women, girls and HIV/AIDS in Southern Africa", 2004. http://womenandaids.unaids.org/regional/docs/Report%20of%20SG%27s%20Task%20Force.pdf, p. 34.
[39] Ibid, p. 29-34.

infection as a result of violence. Girls and women who have been sexually assaulted are at increased risk of HIV infection, through direct transmission and because of the long-term effects of sexual violence on risk-taking behaviour."[40]

67. During the review, violence against women and its link to HIV was cited as a key concern by a wide spectrum of stakeholders across government, the UN and civil society. In addition, the reviewers noted that there is already a growing evidence base – much of which has been developed in South Africa – about the links between HIV and violence. The review team therefore felt that, since gender and violence research protocols have already been established and expertise exists in the region to carry out these studies, it would be interesting and relevant to focus on whether countries have conducted research that seeks to understand the relationship between violence and HIV as an important marker of progress towards engendering national AIDS responses.

68. There are numerous studies that indicate a strong link between gender-based violence and negative health outcomes related to HIV.[41] A study conducted by the South African Medical Research Council found that women with greater power in sexual relationships are more likely to use condoms, or to use them consistently, while women with little power in their relationships are more likely than their peers to contract HIV.[42] Along the same lines, Pulerwitz *et al* found that women who live in abusive relationships are less likely to be able to negotiate in sexual relationships or suggest condom use.[43] There are also clear indications that partner violence inhibits women from adopting self-protective practices such as condom use and accessing voluntary HIV counseling and testing.[44] In addition, men who are sexually violent tend to use condoms less and have higher rates of sexually transmitted infections than other men.[45]

69. There is another major study currently underway – again in South Africa – that specifically examines the effect of interventions to reduce gender-based violence on HIV infections.[46] Gender and HIV specialists point out that there is sufficient global evidence based not only on HIV, but also on contraceptive use and other indicators of women's health, to support the conclusions outlined above, even without studies such as this being replicated in multiple countries. Yet, given country-specific dynamics, and the importance of establishing baseline information for programming, it remains important to ensure that large-scale studies on gendered social behavior and HIV vulnerability are carried out in each country.

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[40] Ibid, p. 5.

[41] See UNAIDS (1999) Gender and HIV/AIDS: taking stock of research and programmes, Geneva: UNAIDS; WHO (2005) "Multi-country Study on Women's Health and Domestic Violence against Women --Initial results on prevalence, health outcomes and women's responses," and WHO (2003) Engendering' the Health Millenium Development Goals (MDGs).

[42] Dunkle K L,Jewkes R K,Brown H C et al.2004.Gender-based violence, relationship power, and risk of HIV infection in women attending antenatal clinics in South Africa. The Lancet. 363 (9419):1415-1421.

[43] Pulerwitz J, Amaro H, De Jong W, Gortmaker SL and Rudd R (2002) 'Relationship power, condom use and HIV risk among women in the USA', in AIDS Care, 14, 789-800.

[44] See Gupta R (2000) Gender, Sexuality and HIV/AIDS: The what, the why and the HIV, Washington DC: ICRW; Jewkes R, Vundule C, Maforah F and Jordaan E (2001) 'Relationship dynamics and teenage pregnancy in South Africa', in Social Science and Medicine, 5, 733-744.

[45] See Barker GF and Acosta F (2002) 'Men, gender-based violence and sexual and reproductive health: a study with men in Rio de Janeiro/Brazil', in Instituto PROMUNDO and Instituto NOOS study report; see also: S C Kalichman and L C Simbayi (2003) "*HIV Testing attitudes: AIDS Stigma and Voluntary HIV counselling and testing in a black township in Cape Town, South Africa." Sexually Transmitted Infections* 79;442-447.

[46] Paul M Pronyk, James R Hargreaves, Julia C Kim, Linda A Morison, Godfrey Phetla, Charlotte Watts, Joanna Busza, John D H Porter, "Effect of a structural intervention for the prevention of intimate-partner violence and HIV in rural South Africa: a cluster randomized trial", *Lancet* 368, 1973-1983, 2006.

70. As **Table 2** below indicates, in most countries since 2004, there has not been a major study seeking to determine the exact incidence of violence against HIV positive women within sexual relationships, nor has there been an attempt to examine HIV prevalence amongst women in abusive relationships. The Soweto MRC study was groundbreaking in this regard, and the Human Sciences Research Council in South Africa has done similar studies on a much smaller scale, looking at incidence of sexually transmitted infections and masculinity issues. Furthermore, as the table indicates, there is very little recent research that has been conducted looking at these factors.

71. In part, this can be attributed to the fact that the early 2000s produced interesting new evidence due to the fact that a number of Demographic Household Surveys (DHS) (Malawi, South Africa, Zambia, Zimbabwe) were completed between 1998 – 2004. In South Africa, the release of the Nelson Mandela study on HIV prevalence in communities in 2002 provided extensive data for researchers to analyze outside the traditional hospital-based surveillance sites typically used in surveys of HIV prevalence.[47] Each of the DHS surveys listed above opted to include a module on gender and domestic violence. This optional module provides rich and important data, and its value for evidence-based planning cannot be overstated. Similarly, the HIV questions within the DHS often ask pertinent questions related to gendered knowledge, attitudes and behaviours, which researchers can use for additional analysis should they wish to. More recently, the Physicians for Human Rights research report provides an extensive analysis of "the effects of gender inequity, stigma and discrimination in Botswana and Swaziland" using interviews with 1268 randomly selected respondents, 50% of whom were aware of their HIV status.[48] It provides invaluable new information on women's lack of control in relationships, as well as the impact this has on their ability to use condoms.

[47] 2002. Human Sciences Research Council. Nelson Mandela/HSRC study of HIV/AIDS: South African national HIV prevalence, behavioral risks, and mass media household survey. Cape Town, South Africa:
[48] 2007. Physicians for Human Rights. *Epidemic of Inequality: Women's Rights and HIV/AIDS in Botswana & Swaziland.* http://physiciansforhumanrights.org/library/report-2007-05-25.html

Table 2: Research on violence against women and HIV [49]

Country	Research demonstrating explicit causal link between violence against women and HIV	Research documenting incidence/ magnitude of violence against women and some links to HIV impacts	Research conducted since 2004	Research documenting attitudes towards violence against women	Research conducted since 2004
Botswana	No	Yes[50]	Yes	Yes[51]	Yes
Lesotho	No	Yes[52]	Yes	Yes	No
Namibia	No	No	No	No	No
Malawi	No	Yes[53,54]	Yes	Yes[55]	Yes
Mozambique[56]	-	-	-	-	-
South Africa	Yes[57,58]	Yes[59,60]	Yes	Yes[61]	No
Swaziland	No	Yes[62]	Yes	Yes [63]	Yes[64]
Zambia	No	Yes [65]	No	Yes[66]	No
Zimbabwe	No	Yes[67]	No[68]	Yes[69]	No[70]

72. There have been a few extremely important studies documenting the prevalence of gender-based violence and attitudes towards women. These include Demographic and Health Surveys in Zimbabwe, Malawi and Zambia, and a number of large-scale NGO surveys in South Africa. In Botswana, a qualitative study was done on attitudes to child sexual abuse but there has been no explicit focus on the nexus between gender-based violence and HIV.

[49] Research conducted between 2004 – present, with a focus on gender-based violence, has been included in this sample. Small studies of less than 500 participants, and/or those that do not include a rigorous sampling methodology, were excluded.
[50] 2005. CIDA. Socio-Economic Factors Contributing to Child Abuse in Botswana; (2007) Epidemic of Inequality: Women's rights and HIV/AIDS in Botswana and Swaziland, Physicians for Human Rights.
[51] Ibid
[52] 2002. MEASURE Evaluation Project. Sexual Violence against Women in Lesotho.
[53] 2004. MEASURE Demographic and Health Survey.
[54] 2005. Institute for Security Studies (ISS). Intimate Partner violence: Results for a National Gender-Based Violence Study in Malawi.
[55] Ibid
[56] Only a partial review was possible due to language. This will be completed as the review moves forward and is completed in October 2007.
[57] 2004. Dunkle K, Jewkes R, Brown H, McIntye J, Gray G and Harlow S. 'Gender-based violence, relationship power, and HIV infection in women attending antenatal clinics in South Africa', *Lancet* 363,1415-1420.
[58] 2005. Simbayi, L.C., Kalichman, S.C., Jooste, S., Cherry, C., Mfecane, S. & Cain, D. Risk factors for HIV/AIDS among youth in Cape Town, South Africa. *AIDS and Behavior*, 9(1): 53–61.
[59] 2004. Dunkle K, Jewkes R, Brown H, McIntyre J, Gray G and Harlow S. 'Gender-based violence, relationship power, and HIV infection in women attending antenatal clinics in South Africa', *Lancet* 363,1415-1420.
[60] 2004 (June). Policy brief: "Every six hours a woman is killed by her intimate partner": A National Study of Female Homicide in South Africa
[61] Ibid.
[62] 2007. Physicians for Human Rights. *Epidemic of Inequality: Women's Rights and HIV/AIDS in Botswana & Swaziland.* http://physiciansforhumanrights.org/library/report-2007-05-25.html
[63] Ibid
[64] 2006. Sonke Gender Justice. "Understanding Men's Perceptions of their own and Government's Responses to Violence Against Women." http://www.genderjustice.org.za/publications/survey-report.html Cape Town.
[65] 2001/2. Zambian Central Board of Health. Demographic and Health Survey
[66] Ibid
[67] The last DHS in Zimbabwe was conducted in 1999, and produced information on attitudes related to gender-based violence (see 2000. MEASURE Final DHS Report: Zimbabwe. http://www.measuredhs.com/pubs/pub_details.cfm?ID=296&srchTp=advanced). However, the country is currently undergoing another DHS.
[68] Ibid.
[69] Ibid.
[70] Ibid.

73. Like the MRC study, the study by Physicians for Human Rights offers important evidence about the extent to which women's choices are limited by their participation in violent and controlling relationships. There can be no doubt about the impact this has on their vulnerability to HIV infection. It will be important for countries such as Lesotho, Namibia, Mozambique and Zambia to replicate these studies and that the results of these studies are used to improve programming. For those countries that have done major research, it will be necessary to regularly repeat these to monitor for changes over time. Already the DHS surveys carried out in Malawi and Zambia are beginning to be outdated, and will require updating in the next few years.

INITIAL CONCLUSIONS

74. In the last three years, there has been significant progress made in the countries that participated in the Secretary-General's Task Force on Women, Girls and HIV/AIDS in Southern Africa. Yet there is much more to be done. The review revealed that progress on designing and rolling out programmes that address gender equality and harmful gender norms has been slow. Furthermore, programme planners are increasingly recognizing that "interventions focused solely on individual behavior will not address the factors creating vulnerability to HIV for women and men."[71] There must be an increase in resources for programmes focused on changing social norms, not as once-off grants, but as part of the sustained and systematic giving patterns of donors and development partners. The challenges encountered in each country are not unique to gender and HIV: poor capacity, weak structures and insufficient funding. Yet when it comes to matters of gender inequality, not facing these challenges can have devastating effects on the lives of individuals, families and communities. As national and international stakeholders move forward in creating ever more sophisticated national responses to HIV, and as they increasingly adopt the "Three Ones" and harmonized and aligned funding approaches, it will be essential that support to gender equality be recognized as a core component in the fight against HIV.

    A. **It is time to embed gender efforts into the Three Ones – one national AIDS coordinating authority, one national HIV strategic framework, one national monitoring and evaluation system**. In a number of Task Force countries, gender efforts have often been "tacked-on" to national HIV efforts rather than included as part of ongoing planning or review processes. The result is that gender concerns are often missing in critical areas within national strategy documents and annual operational plans. Furthermore, monitoring and evaluation frameworks tend to be weak on gender. Gender assessments and reviews must be integrated into mainstream HIV planning and programming processes.

    B. **Accountability for gender-related HIV programming must be established.** Lessons from the HIV response show that it is absolutely critical for there to be clarity on where leadership and accountability lie, including for gender and HIV. This priority must be reflected and responded to by all, but it must be clear who leads and brings together the efforts and actors to enable this to happen, and what mechanisms are in place to allow the various stakeholder groups to agree on, plan for, and monitor and evaluate progress on common gender and HIV priorities. Ultimate accountability should remain with the National AIDS Coordinating Authority.

[71] 2007. Physicians for Human Rights. *Epidemic of Inequality: Women's Rights and HIV/AIDS in Botswana & Swaziland,* p.1. http://physiciansforhumanrights.org/library/report-2007-05-25.html

C. **It is time to move beyond gender and HIV policy to strengthening gender and HIV programmes.** Many stakeholders continue to focus on advocacy and policy-level activities aimed at raising the awareness of policy-makers about the links between gender inequality and HIV. This has paid handsome dividends: political statements by senior leaders pledging support to gender equality in the fight against HIV have become commonplace. Yet the Three Ones and efforts to harmonize and align HIV funding have not been sufficiently leveraged to support gender *programming* in the context of national AIDS plans and programmes. Policy documents and introductory and analytical sections of key national documents include strong statements affirming gender equality but are not matched at the operational level of plans and funding documents. In addition, gender sensitive indicators and activities tend to be missing from these documents. Governments, supported by the UN and donors, should focus on the development and expansion of gender-related projects that are known to be effective, including prevention programmes that address gender-based risk-taking behaviours and vulnerabilities of men and women to HIV.

D. **Build the momentum on gender and HIV research.** While important research that demonstrates the links between sexual violence and women's vulnerability to HIV infection has been conducted through the years, the knowledge gained has not answered all the questions nor been adequately built upon or updated. Nor has the gender discourse caught up with the new ways in which the epidemic is being understood and discussed. More operational research should be undertaken to better understand men's and women's participation in sexual networks, how women experience services such as voluntary testing and counselling since so many women only access testing services when they are pregnant, and how and why men seek, or do not seek, health services. These are major issues in heterosexual epidemics like in Southern Africa.

E. **Developing and using national and regional gender expertise is essential.** Whereas women's groups and men's groups working on transforming harmful gender norms were largely uninvolved in HIV activities three years ago, many are actively involved today. This is a major achievement that needs to be further reinforced and solidified. However, many of these groups and dedicated individuals lack the technical skills in gender and HIV programming to shape large programmes that will provide services to women and men using public health approaches that are gender-sensitive. These organisations need to be further supported in terms of capacity building to be able to make a more meaningful input. At the same time, the public health experts who are at the centre of national AIDS responses remain ill equipped (technically and in terms of the human capacity with in key institutions such as National AIDS Councils and Ministries of Health, Education and Finance) to respond with the requisite operational detail to make a difference. Within the UN system, which often sets itself up as the premier provider of technical assistance, there are few gender theme groups, and most country offices do not have gender and HIV expertise on staff. Gender expertise exists at country and regional levels but is not adequately utilized. There is a need to tap into national universities and research institutions, which often have some capacity for gender analysis, and to invest in these institutions so that they increase their skills in gender analysis and sexual and reproductive health and HIV programming.

F. **Developing gender and HIV guidance for and among donors is critical**. Given the Paris Declaration on Aid Effectiveness and the consequential move towards aid harmonisation and the Three Ones, and the increasing prominence of the Global Fund, the World Bank Multi-Country HIV/AIDS Programme, and other

large pots of funding, the amount of resources that donors can commit to a gendered response will increasingly be determined by what is agreed on in the ‘common basket’. There is a need to ensure that guidelines are designed for national funding processes, including basket-funding processes to ensure inclusion of gender within HIV programmes, that these are operationalised at country level, and that civil society groups, including those that champion gender equality in the context of HIV, are not left out of discussions and agreements between States, bilaterals and multilaterals.

ANNEX I

SECRETARY GENERAL'S TASK FORCE ON WOMEN, GIRLS AND HIV/AIDS IN SOUTHERN AFRICA (ORIGINAL TASK FORCE MEMBERS) NOVEMBER 2003

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

ANNEX II

ORGANIZATIONS CONTACTED DURING THE REVIEW – FEBRUARY TO JUNE 2007

BOTSWANA
Botswana Network on Ethics, Law and HIV/AIDS
Botswana Network of AIDS Service Organisation
Botswana/USA Partnership/ President's Emergency Plan for AIDS Relief
Ministry of Health
National Department of Women's Affairs
National AIDS Coordinating Authority
Parliamentarians for Women's Health
UNAIDS Secretariat
UNDP
UNFPA
UNICEF
University of Botswana
UN Theme Group on HIV and AIDS

LESOTHO
Irish Aid, Embassy of Ireland
Lesotho National Council of Women
Lesotho Network of People Living with HIV/AIDS
Member of Parliament and Former UN Secretary General's Task Force member for Women Girls and HIV/AIDS in Southern Africa
Ministry of Health and Social Welfare
Ministry of Gender, Youth Sports and Recreation
National AIDS Commission
Positive Action
UNDP
UNFPA
UNICEF

MALAWI
DAGG Theme Group
Ministry of Gender
Ministry of Education
National AIDS Council
NGO Gender Network
Society for Women and AIDS, Malawi
UNDP Gender Group
UN Interagency Gender Group
UNAIDS

MOZAMBIQUE
Associação Moçambicana das Mulheres de Carreira Juridica
Canadian International Development Agency

Flanders Project: *Addressing the Feminisation of HIV/AIDS*
Fórum Mulher
Gabinete da Mulher Parlamentar (Women's Parliamentary Forum)
Kuyakana
Mozambican Network of AIDS Service Organisations
National AIDS Council
National Directorate for Health Promotion & Disease Control Ministry of Health
Ministry of Education and Culture
Ministry of Health
National Directorate for Women
Ministry of Women and Social Action
Police Department
Parliamentary Committee on HIV and AIDS
Rede Nacional de Associcoes de Pessoas Vivendo Com HIV/SIDA
UNAIDS
UNDP
UNICEF

SOUTH AFRICA
City of Johannesburg
Centre for Health Policy
Engender Health
Health Systems Trust
Positive Women's Network
Reproductive Rights Alliance
South African National AIDS Council
UNAIDS Secretariat
UNICEF
UN Resident Coordinator
UN Theme Group Chair
Women's Net

SWAZILAND
Coordinating Assembly of NGO's
European Union
Gender Unit, Ministry of Home Affairs
International Community of Women Living with HIV
Sebenta
Swaziland Action Group Against Abuse
Women and Law in Southern Africa Trust
UNAIDS
UNDP
UNFPA
United States Government HIV/AIDS PEPFAR Swaziland - President's Emergency Plan For AIDS Relief
WFP