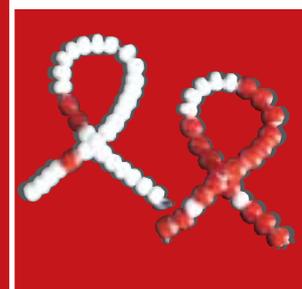# AT THE CROSSROADS:

Linking Strategic Frameworks to Address Gender-Based Violence and HIV/AIDS in Southern Africa

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ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ARV's	Anti-retrovirals
ART	Anti-retroviral treatment
AU	African Union
DRC	Democratic Republic of Congo
HIV	Human Immuno-deficiency Virus
GBV	Gender-based violence
MDG's	Millennium Development Goals
NEPAD	New Partnership for African Development
OAU	Organisation of African Unity
PEP	Post-exposure prophylaxis
PMTCT	Prevention of mother-to-child-transmission
RISDP	Regional Indicative Strategic Development Plan
SADC	Southern African Development Community
STI's	Sexually transmitted infections
TB	Tuberculosis
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations Children's Fund
UNIFEM	United Nations Development Fund for Women
VCT	Voluntary counseling and testing
WHO	World Health Organisation

SECTION 1: INTRODUCTION

"[W]hile societies will have to deal with AIDS for some time to come,
the extent of the epidemic's impact will depend on the response and
investment now. Applying and sustaining the learning of the last
20 years will make a fundamental difference to Africa's future."

[UNAIDS *AIDS in Africa: Three Scenarios to 2025* (2005) at 12]

1. Background to this study

According to statistics released by UNAIDS & WHO in 2007, southern Africa is still "the global epicentre of the AIDS pandemic",[1] with national adult HIV prevalence equaling or exceeding 15% in nine countries here.[2] The subregion accounts for 35% of all people living with HIV globally in 2007 and almost one third (32%) of all new HIV infections and AIDS deaths.[3]

In spite of this discouraging picture, there have also been some positive developments. By December 2006, sub-Saharan Africa was estimated to have more than 1.3 million people on antiretroviral treatment, with coverage of 28%, whereas three years earlier there were 100 000 people on treatment and coverage amounted to only 2%.[4] Most of this trend is due to increased treatment access in a few countries (notably Botswana, Kenya, South Africa, Uganda and Zambia).[5] In Zimbabwe, data from national senti-nel surveillance and national and local community-based surveys show a significant decline in HIV prevalence.[6]

In recent years, southern African governments have made a number of important commitments on international and regional levels to combat HIV/AIDS. The subregion has also seen a number of strategic developments such as the drafting and implementation of the *SADC HIV/AIDS Policy Framework for 2003-2007* and the appointment by the UN Secretary-General of a *Task Force on Women, Girls and HIV/AIDS in Southern Africa*.

It is now generally accepted that the intersections between gender-based violence and HIV/AIDS are among the most significant of the gendered dimensions of this pandemic. It is noteworthy that the *UN Special Rapporteur on Violence Against Women* devoted her 2005 thematic report to these intersections.[7] She observed that while some progress is being made separately on ending violence against women and on stemming the spread of HIV/AIDS, national and international efforts would be vastly more effective if they addressed the interconnectness between the two pandemics.[8]

This interconnectness is primarily to be found in *gender inequality*: the same factors that expose women to gender-based violence also increase their vulnerability to HIV infection.[9] For this reason, the Special Rapporteur proposes that an understanding of the interplay between gender inequality, violence and HIV can offer "plausible areas of intervention" to fight the pandemic effectively.[10] A further observation by the Special Rapporteur also applies in the southern African context:

"*In spite of the number of women contracting HIV/AIDS through violent means, States have yet to fully acknowledge and act upon the interconnection between these two mutually enforcing pandemics. By and large, Governments fail to take into consideration gender discrimina-tion in formulating HIV/AIDS policies.*"[11]

Against this background, we have identified a need to consolidate existing information on the integration of gender-based violence and HIV/AIDS on policy level in southern Africa, in order to identify the "plausible areas of intervention" referred to by the UN Special Rapporteur.

A question that arises is why it is necessary to focus on policy development on subregional (in addition to national) level. Countries in southern Africa are interconnected culturally, economically, and in terms of human migration; this also means that the subregion needs to build on this same level of integration in its approach to containing the HIV/AIDS epidemic.[12] Experiences of subregional action on other shared challenges have demonstrated the power of a unified approach within SADC.[13] This means that the impact of national efforts can be improved by greater consistency in focus and approach to common drivers of the epidemic across SADC. A shared subregional approach allows, for example, for the development of uniform standards for HIV/AIDS programming based on evidence of successful models.[14]

2. Objective of the study

The objective of this study is therefore to examine the existing subregional policy frameworks aimed at addressing both gender-based violence and HIV/AIDS in the southern African context, and to establish to which extent these frameworks acknowledge each other and are interlinked. In order to conduct this examination, it is necessary to also look at certain of the political commitments that governments have undertaken, since these form the underlying structure for the development of these policies.

Who is this report intended for?

The purpose of this report is to assist in the development and enhancement of interlinked gender-based violence and HIV/AIDS policy frameworks at subregional level, and where applicable, at national level in southern Africa. This report is therefore intended to be of use to policy-makers, researchers, non-governmental organisations and activists working in these sectors.

This report forms part of a broader project that aims to promote gender democracy in southern Africa by addressing the critical intersections between gender-based violence and HIV/AIDS by -

- Supporting the establishment of a network of organizations working to address the intersections between GBV and HIV/AIDS in the SADC subregion;
- Sharing information, building capacity and stimulating public debate on the intersections between GBV and HIV/AIDS; and
- Contributing to the research base on the subject of gender-based violence and HIV/AIDS in the SADC subregion.

Previous activities by the Gender Project aimed at meeting these objectives have included launching a newsletter entitled *Iminyango*,[15] which provides information on the intersections between gender-based violence and HIV/AIDS in southern Africa. The Project has also established a website,[16] which is intended to complement the newsletter and provide access to additional material and resources.

Limitations and Disclaimers

The scope of this report does not permit a comprehensive audit of national legislation and policies relating to the intersections of gender-based violence and HIV/AIDS, but should lay the basis for such an analysis at a later stage.

The study was subject to certain limitations, including the fact that it was desk-based. Secondly, the authors admit to a degree of South African bias (given that this is where the study was located and the resultant availability of material), as well as an Anglophone bias. It is hoped that this will be corrected in later stages of this project.

3. Concepts

This report makes use of the term *"gender-based violence"*, which has been defined as follows: "violence that is directed against a woman because she is a woman or that affects women disproportionately".[17] It also uses *"violence against women"*, which is described as "acts of gender-based violence that result in, or are likely to result in, physical, sexual, or psychological harm or suffering to women".[18]

This report uses the terms, with reference to different source documents, *"traditional practices"*, *"cultural"* and *"customary"* practices and *"harmful practices"*. (These terms are not necessarily used synonymously.)

The Protocol on the Rights of Women in Africa[19] defines "*harmful practices*" as "all behaviour, attitudes and/or practices which negatively affect the fundamental rights of women and girls, such as their right to life, health, dignity, education and physical integrity".[20] Since this is a very broad definition, we derived additional guidance from the following explanation provided by the Office of the High Commissioner for Human Rights:

"*Traditional cultural practices reflect values and beliefs held by members of a community for periods often spanning generations. Every social grouping in the world has specific traditional cultural practices and beliefs, some of which are beneficial to all members, while others are harmful to a specific group, such as women. These harmful traditional practices include female genital mutilation (FGM); forced feeding of women; early marriage; the various taboos or practices which prevent women from controlling their own fertility; nutritional taboos and traditional birth practices; son preference and its implications for the status of the girl child; female infanticide; early pregnancy; and dowry price. Despite their harmful nature and their violation of international human rights laws, such practices persist because they are not questioned and take on an aura of morality in the eyes of those practising them.*"[21]

The term *"southern Africa"* is used here to refer to the fourteen countries that constitute the member states of the Southern African Development Community (SADC). These countries are: Angola, Botswana, Democratic Republic of the Congo (DRC), Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, South Africa, Swaziland, Tanzania, Zambia and Zimbabwe. O'Grady reminds us that the subregion's socio-economic landscape range from the "world class" cities of Cape Town and Johannesburg in South Africa to the distressing conditions in the war-torn Democratic Republic of Congo.[22] To these variables one could also add political (in)stability, with Zimbabwe a cause for concern in this regard at the time of writing. It is therefore precarious to construct a single, monolithic "southern African" position – at best, this report attempts to identify current trends in the subregion.

We use the phrases "HIV/AIDS" and "HIV and AIDS" interchangeably. The latter is specifically employed where we make reference to other documents relying on this term.

1 See discussion below.

2 UNAIDS & WHO *AIDS Epidemic Update* (December 2007) at 15-17. These countries are Botswana, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Zambia and Zimbabwe.

3 UNAIDS & WHO (above) at 8.

4 WHO et al *Towards Universal Access: Scaling Up Priority HIV/AIDS Interventions in the Health Sector* (April 2007) at 5.

5 UNAIDS & WHO *Report on the Global AIDS Epidemic* (2006) at 17.

6 UNAIDS & WHO *AIDS Epidemic Update* (2007) at 16.

7 UN Special Rapporteur on Violence Against Women, Its Causes and Consequences *The Intersections of Violence Against Women and HIV/AIDS* (17 January 2005) Ref E/CN.4/2005/72.

8 UN Special Rapporteur on Violence Against Women (above) at 2.

9 (Above) at Par 21.

10 (Above) at Par 19.

11 (Above) at Par 81.

12 SADC *Towards Universal Access to HIV Prevention: SADC Strategic Action Plan 2008-2010* (August 2007) at 8.

13 SADC *Towards Universal Access* (above) at 3.

14 SADC *Towards Universal Access* (above) at 3. Although these observations were made in the context of *prevention* programming, we argue that they also apply in the broader context of HIV/AIDS treatment, care and support programmes.

15 "Iminyango" is the isiZulu word for "doors". This title was derived from an explanation that a survivor of domestic violence had given on the intersection between gender-based violence and HIV/AIDS (she had also contracted HIV from her abusive partner): "Gender-based violence happens behind closed doors and HIV is killing women behind those closed doors. The solution is to break down those doors."

16 The website can be accessed at www.gbvhiv.org.za.

17 Committee on the Elimination of Discrimination Against Women General Recommendation No 19, UN GAOR, 11th Session, UN Doc CEDAW/C/1992/L.1/Add.15 (1992) Art 6.

18 Declaration on the Elimination of Violence Against Women, UN GAOR 48th Session UN Doc A/Res/48/104 (1994) Art 1.

19 Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa adopted on 11July 2003.

20 Art 1(g). See also Art 5 of the Convention on the Elimination of All Forms of Discrimination Against Women adopted 18 December 1979, G.A. Res 34/180, UN GAOR, 34th Session, Supp No 46, UN Doc A/34/36 (1980).

21 Office of the High Commissioner for Human Rights *Fact Sheet Number 23: Harmful Traditional Practices Affecting the Health of Women and Children* (undated).

22 M O'Grady "The impoverishing pandemic: the impact of the HIV/AIDS crisis in southern Africa on development" in *Development Update - From Disaster to Development: HIV and AIDS in Southern Africa* (December 2004) Vol 5 No 3 at 26.

SECTION 2: UNDERSTANDING THE CONTEXT

1. Introduction

In this section, we provide a brief outline of the current position in southern Africa regarding HIV/AIDS through an overview firstly of the extent of the national epidemics and secondly of the impact of HIV/ AIDS in the subregion. We subsequently look at background information regarding gender-based violence in southern Africa. We then examine a concept central to this report, ie the intersection between gender-based violence and HIV/AIDS, and also recount the findings of the UN Secretary-General *Task Force on Women, Girls and HIV/AIDS in Southern Africa* regarding violence against women and girls in some detail. Finally, we look at where HIV/AIDS and gender fit into the broader SADC picture.

2. HIV/AIDS in Southern Africa

According to the UNAIDS & WHO *2007 AIDS Epidemic Update*, the estimated number of persons living with HIV worldwide in 2007 was 33.2 million.[1] **Sub-Saharan Africa** remains the region most severely affected: more than two thirds (68%) of adults and nearly 90% of children infected with HIV live in this region, where more than three quarters (76%) of all AIDS deaths in 2007 occurred.[2] It is estimated that 1.7 million people were newly infected with HIV in 2007, bringing to 22.5 million the total number of people living with the virus. Unlike other regions, the majority of people living with HIV in sub-Saharan Africa (61%) are women.[3]

Within sub-Saharan Africa, the scale and trends of epidemics vary considerably. As stated above, the impact is most severe on **southern Africa**: the subregion accounts for 35% for all people living with HIV and almost one third (32%) of all new HIV infections and AIDS deaths globally in 2007.[4]

Table 1 summarises recent information regarding national adult HIV prevalence, as contained in the *2007 AIDS Epidemic Update* and other sources. This national prevalence exceeded 15% in eight countries in southern Africa in 2005 (Botswana, Lesotho, Mozambique, Namibia, South Africa, Swaziland, Zambia and Zimbabwe), with Malawi's prevalence also between 15-17%. Although there is evidence of a significant decline in the national HIV prevalence in Zimbabwe, the epidemics in most of the rest of subregion have either reached or are approaching a plateau. In Mozambique the latest HIV data (in 2005) have shown an increase in prevalence over the previous surveillance period.[5]

What is encouraging is that the information from Zimbabwe shows that declines are (at least in part) attributable to behavioural changes. The *2007 AIDS Epidemic Update* reports that there is evidence from eastern Zimbabwe that more women and men have been avoiding sex with non-regular partners, and that consistent condom use with non-regular partners increased for women (from 26% in 1998-2000 to 37% in 2001-2003), though not for men.[6] Mathematical modelling also suggests that the declines in HIV prevalence could not be attributed solely to the natural evolution of Zimbabwe's AIDS epidemic but are in part due to behavioural change. There is also evidence from Malawi that behavioural changes can reduce the risk of HIV infection.[7]

Table 1: Overview of Epidemic Update for Southern African Countries[8]

COUNTRY	CURRENT HIV PREVALENCE	DESCRIPTION OF TRENDS
Angola	Median national HIV prevalence estimated at **2.5%** in 2005.	Not much change between 2004 and 2005.
Botswana	HIV prevalence among pregnant women attending antenatal clinics: **32%** in 2006 Pregnant women 15-19 years: 18% Pregnant women 20-24 years: 29%	Decrease in HIV prevalence among pregnant women attending antenatal clinics in recent years suggests that epidemic has reached its peak and could be on the decline. Decline in infection levels from 2001 – 2006: General: from 36% to 32%. Young pregnant women 15-19 yrs old: from 25% to 18% Pregnant women 20-24 yrs old: from 39% to 29%.
DRC	HIV prevalence among antenatal clinic attendees varies from **3.8%** in Kinshasa to **6-8%** in other cities.	HIV prevalence has remained relatively stable in the capital, Kinshasa, but has risen in other cities. Reliable data is not available for the whole country.
Lesotho	HIV prevalence among antenatal clinic attendees of **38%** in the 25-29-year-age group in 2005.	Most recent data show a decline in infection levels among young (15-24 years) pregnant women from about 25% in 2003 to 21% in 2005, but this apparent decrease might be due to the addition of new sentinel surveillance sites in the most recent survey.
Madagascar	Recent data collected from pregnant women using antenatal services show national HIV prevalence of **0.2%.**	
Malawi	Median HIV prevalence among pregnant women at sentinel surveillance sites has remained between **15%** and **17%** since 2000.	Epidemic appears to have stabilized with declines in some local areas and amid some evidence of behavioural changes that can reduce the risk of acquiring HIV infection.

Table 1: Overview of Epidemic Update for Southern African Countries[8] (continued)

COUNTRY	CURRENT HIV PREVALENCE	DESCRIPTION OF TRENDS
Mauritius	National adult prevalence of **0.6%**, but prevalence is higher among high-risk populations (prison inmates, injecting drug users and sex workers).[9]	Exposure to non-sterile drug injecting equipment is the main risk factor for HIV infection: about three quarters of the HIV infections diagnosed in the first six months of 2004 were among injecting drug users.
Mozambique	HIV prevalence among women attending antenatal clinics is lowest in the north (average of **9%** in 2004), but in the central and southern zones prevalence of **20%** or more has been found, including in the capital, Maputo, and in Gaza, Inhambane, Manica and Sofala provinces (where it reached almost **27%** in 2004).	Epidemic has again started to increase in all three zones after appearing to have stabilized in the early 2000s.
Namibia	One in five women (**20%**) attending antenatal clinics tested HIV-positive in 2006.	Epidemic appears to have stabilized. The relatively stable trend since the mid-1990s in HIV prevalence among young pregnant women (15-24 years), and the rising trend among those in their 30s suggest that prevention efforts need to be improved.
South Africa	Prevalence among pregnant women at **29%** in 2006.	Data from latest round of antenatal clinic surveillance suggest that HIV infection levels might be levelling off, with prevalence among pregnant women at 30% in 2005 and 29% in 2006. In addition, decrease in HIV prevalence among young pregnant women (15-24 years) suggests a possible decline in the annual number of new infections.
Swaziland	According to a new population-based survey, **26%** of adults (15-49 years) are infected with HIV.	

Table 1: Overview of Epidemic Update for Southern African Countries[8] (continued)

COUNTRY	CURRENT HIV PREVALENCE	DESCRIPTION OF TRENDS
Tanzania	HIV prevalence in mainland Tanzania was **8.7%** among women using antenatal services in 2003-2004, down from 9.6% in 2001-2002, while among antenatal clinic attendees in Zanzibar it ranged from **0.7%** in Unguja to **1.4%** in Pemba.	HIV prevalence shows a decline.
Zambia	HIV prevalence among pregnant women is twice as high in urban as in rural areas (**25%** versus **12%**).	Apparent decline in some parts of the country: prevalence has declined among 20 to 24-year-old pregnant women in urban areas (where it dropped from 30% in 1994 to 24% in 2004) as well as among 15-19-year-old pregnant women (down from 20% in 1994 to 14% in 2004).
Zimbabwe	HIV prevalence among pregnant women in 2006: **18%** Young pregnant women (15-24 years): 13%.	Significant decline in the past few years. Pregnant women generally: from 26% in 2002 to 18% in 2006. Among young pregnant women (15-24 years) prevalence declined from 21% to 13% over the same period. Trend reflects a combination of very high mortality and declining HIV incidence, related in part to behaviour change.

3. The Impact of HIV/AIDS in Southern Africa

The progress report prepared for the 2006 follow-up to the 2001 UN General Assembly Special Session describes the impact of the AIDS pandemic as follows:

"*Among the 40 million people currently living with HIV, more than 95 per cent are in developing countries. In the hardest-hit countries, the very foundations of society, governance and national security are being eroded, stretching traditional safety nets to the breaking point and leading to social and economic repercussions that are likely to span generations.*"[10]

The report continues to explain that the AIDS burden, which is growing especially severe for women and girls, is not only an unprecedented public health challenge, but also represents a profound threat to prospects for poverty reduction, child survival and economic development.[11] This observation is line with the UNAIDS & WHO report from the same year, which stated that the findings of recent research had shown how AIDS exacer-

bates other major development challenges, from the deterioration of public services and governance to human emergencies such as food insecurity and conflict.[12]

It is significant to note that during recent years, the Human Development Index[13] has been

rising across all developing regions, with the obvious exception of sub-Saharan Africa, where twelve countries registered lower scores on the HDI in 2003 than in 1990.[14]

Table 2: Human Development Indicators[15]

	Country	Human Develop-ment Index Rank	Life expectancy at birth (yrs)	GDP per capita (PPP US$)	Probability at birth of not surviving to age 40+ (% of cohort)	Population below income poverty line (%)	
						$1 a day	$2 a day
1	Angola	162	41.7	2,335	46.7	..	..
2	Botswana	124	48.1	12,387	44	28	55.5
3	DRC	168	45.8	714	41.1	..	..
4	Lesotho	138	42.6	3,335	47.8	36.4	56.1
5	Madagascar	143	58.4	923	24.4	61	85.1
6	Malawi	164	46.3	667	44.4	20.8	62.9
7	Mauritius	65	72.4	12,715	5.1	..	..
8	Mozambique	172	42.8	1,242	45	36.2	74.1
9	Namibia	125	51.6	7,586	35.9	34.9	55.8
10	South Africa	121	50.8	11,110	31.7	10.7	34.1
11	Swaziland	141	40.9	4,824	48	47.7	77.8
12	Tanzania	159	51	744	36.2	57.8	89.9
13	Zambia	165	40.5	1,023	53.9	63.8	87.2
14	Zimbabwe	151	40.9	2,038	57.4	56.1	83

Only one of the fourteen southern Africa countries, Mauritius, is currently classified as a "High Human Development" country. Six countries (South Africa, Botswana, Namibia, Lesotho, Swaziland and Madagascar) rank among the "Medium Human Development" countries, while the remaining seven listed above are all classified as "Low Human Development". Mozambique, with a HDI rank of 172, is near the bottom of the list of 177 countries. The reversal of the developmental gains made in the subregion in the last 30 years is frequently cited as one of the major consequences of the HIV/AIDS pandemic in southern Africa.[16]

UNAIDS reports that in the most severely affected countries of sub-Saharan Africa, AIDS continues to slow or reverse improvements in life expectancy and distort the age-sex structures of entire populations.[17] The steady progress towards improved life expectancy that was being made until the advent of the epidemic has been eroded. Part of the impact of AIDS on life expectancy in sub-Saharan Africa is due to child mortality, either directly or indirectly due to AIDS. However, the biggest increase in mortality has been among adults aged 20-49 years, reversing the previous distribution of deaths according to age. Whereas

this age group had accounted for only 20% of all deaths between 1985 and 1990, today they account for almost 60%. This phenomenon reverses the usual pattern of disease-related mortality, normally concentrated among the very young and very old. Instead, AIDS strikes down adults in their most economically productive years and removes the very people who could respond to a crisis.[18]

"*In 2003 alone, Lesotho lost a third of its health workers and 15 per cent of its teachers. In Zambia, AIDS killed teachers twice as fast as replacements could be trained. The disease had killed nearly 8 million African farmers - more than the number of farmers in North America and the European Union combined... Most governments in the region, as well as regional bodies such as SADC, are less well equipped to deal with the crisis than before. By 2002 they faced pressure on public budgets and loss of staff to HIV/AIDS.*"[19]

The high prevalence of HIV in Southern Africa is not only having an impact in terms of lost lives and reduced life expectancy, but also on food security, education and other areas.[20] Food insecurity has recently been reported in South Africa,[21] Zimbabwe, Mozambique and Malawi.[22]

4. Gender-based violence and HIV/AIDS[23]

In recent years, the HIV pandemic has increasingly come to be viewed as strongly gendered, which means that there has been a recognition that the pandemic affects women and men differently.[24] In practice, this firstly consists of women facing a higher risk of HIV infection than men. For example, as explained above, in 2007 almost 61% of adults living with HIV in sub-Saharan Africa were women.[25] (At the same time, the proportions of women living with HIV in Latin America, Asia and Eastern Europe are slowly growing.[26]) Secondly, women also generally bear the responsibility of providing care for persons ill with AIDS-related diseases.[27]

A complex interaction of physiological, socio-cultural and economical factors contributes to women being more susceptible to HIV infection than men. The inherent *physiological* or *biological* risk factors that cause women and girls to be more vulnerable to infection through heterosexual activity (compared to men) include –

- The fact that semen contains higher levels of the virus than vaginal fluids.[28] (It is important to consider that in southern Africa HIV is currently spreading predominantly through heterosexual contact.[29])
- The vagina offers a larger surface area of mucosal tissue through which the virus can enter the bloodstream than the penis.[30]
- This area is also subject to micro-injuries (especially during forced intercourse or as a result of practices such as "dry sex"[31]).
- Women are more susceptible to sexually transmitted infections than men, which allows for easier transmission of the virus.[32] O'Grady reminds us that since many STI's are asymptomatic in women, or women are not aware of their STI symptoms and what they signify, they remain unaware of their risks.[33]

Young women especially are at higher risk of HIV infection than are older women because the vagina and cervix are less mature and less resistant to HIV and other sexual transmitted infections such as chlamydia and gonorrhea.[34] This is linked to changes in the reproductive tract during puberty that make the tissue more susceptible to HIV transmission, and to the fact that young women produce less of the vaginal secretions that provide a barrier to HIV in older women.[35]

In addition to these physiological or biological factors, women's increased vulnerability to HIV infection may also be linked to *cultural expectations and gender roles*. Women's relatively low status in society manifests itself in limited access to education, housing, health and social welfare services. Lower rates of employment result in

inequalities in terms of access to resources and information. Many women therefore find themselves at risk of HIV infection because they lack information on preventative measures as well as access to treatment and care.[36] Traditional and cultural practices such as polygyny, payment of lobolo (bridewealth) and widow inheritance may also increase women's susceptibility to HIV infection.[37]

In the African context, much of the agricultural work is done by women, especially in the case of subsistence farming.[38] The arduous nature of this work involves long working hours with few breaks for rest, lifting and carrying heavy loads, prolonged bending and stooping, exposure to extreme weather conditions, and biological and chemical agents potentially damaging to health. It is difficult to imagine a person ill with an HIV-related disease performing this work on a daily basis. The ILO reported in 2004 that women working on large-scale farms in Zimbabwe have shown the highest levels of illness.[39] Many do not seek health care for fear of losing their jobs.

Where women are socialized to be submissive to their husbands or the male head of the household, this may have an impact on their access to HIV services,[40] for instance, if they feel that they must obtain their husbands' or partners' permission to undergo an HIV test. Human Rights Watch has observed that "like gender-based violence, these gender norms and socialization often shape women's attitudes toward seeking healthcare, including HIV testing and counseling, with devastating results".[41]

On an *economic* level, poverty increases women's vulnerability to HIV infection in that it leads to poor nutrition, inadequate sanitation and susceptibility to opportunistic diseases and infections.[42] Unequal access to resources result in women being more likely to engage in high-risk survival practices, which may include the exchange of sex for food, shelter, money and other resources.[43] The UN Secretary-General Task-Force on

Women, Girls and HIV in Southern Africa notes that southern Africa has the highest average proportion of female-headed households in sub-Saharan Africa.[44] Already among the poorest, these women bear the burden of ensuring the survival of their families, resulting in a high likelihood of transactional sex as a survival strategy.

Although the above factors are important in themselves, gender-based violence has been identified as a key factor in women's heightened risk of contracting the virus.[45] For example, because rape is by definition non-consensual, it has a higher risk of leading to HIV infection by virtue of physical injury to the women's genitalia or anus.[46] For many women, the threat of violence exacerbates their risk of contracting HIV.[47] Fear of violence may prevent women from accessing HIV/AIDS information, being tested, disclosing their HIV status, accessing services for the prevention of HIV transmission to infants and receiving treatment and counseling, even when they know they have been infected.[48]

Significantly, the UN Secretary-General's Task Force on Women, Girls and HIV in Southern Africa identified violence against women in relationships as one of the key factors that contribute to the greater vulnerability of the sub-region's women and girls to HIV infection.[49] For many women, the risk factor is living with an HIV-positive husband or partner (whether he is aware of his status or not).[50] The results of a study carried out among pregnant women at health centres in Soweto showed that experience of violent and controlling behaviour from male partners is associated with increased risk of HIV infection for women.[51]

Because of the effects of poverty, women may stay in violent (and thus high-risk) relationships because they have nowhere else to go.[52] They may also commence to use alcohol or illegal drugs (as a mechanism to cope with the violence), which in turn leads them to engage in high-risk sexual behaviour such as unprotected sex.[53]

Human Rights Watch reports that in sub-

Saharan Africa, women's unequal property rights also contribute to the HIV/AIDS epidemic in the region.[54] Under the laws and customs of many sub-Saharan African countries, women neither inherit nor keep property upon divorce on an equal basis with men. This reinforces their dependence on men, sometimes locking them in abusive relationships. This may also render women and their children destitute upon divorce or the death of their husbands.[55]

In these ways, gender-based violence can be both a cause and a consequence of HIV infection. Significantly, the same factors that render women vulnerable to HIV infection and limit their ability to take preventive health measures also increase their vulnerability to gender-based violence. At the heart of these factors lies the fundamental imbalance of power resulting from women's inequality.[56]

At a meeting convened by the SADC secretariat in 2006,[57] experts identified the key drivers of the epidemic in southern Africa as multiple and concurrent sexual partnerships for both men and women with low consistent condom use,[58] and in a context of low levels of male circumcision.[59] Male attitudes and behaviours, intergenerational sex, sexual violence, stigma, lack of openness, untreated viral STIs and lack of consistent condom usage in long-term multiple and concurrent partnerships were identified as significant *contributing drivers* of the epidemic. Underlying these drivers are *social and structural factors* such as high population mobility, inequalities of wealth, cultural factors and gender inequality that render young women especially vulnerable to HIV infection.

Specific ways in which gender-based violence and HIV overlap

As explained above, sexual violence committed by a man living with HIV can contribute *directly* to an increased risk of transmission of the virus to his partner.[60] Women in violent relationships may also be at risk more *indirectly* by being unable to negotiate the use of safer sex methods,[61] such as condoms, or by being unable to insist on monogamy in their relationships. In this way, they are exposed to an increased risk of HIV transmission, even where the sexual intercourse may be nominally consensual. Furthermore, research has shown that women who have experienced child sexual abuse and intimate partner violence are more likely to engage in high-risk sex.[62]

Conversely, domestic violence may arise as a result of HIV infection. On disclosure of their HIV positive status, many women face abandonment and greater risk of violence from their partner, as well as rejection and ostracization from their families and communities.[63]

In this context, it is important to consider that "domestic violence" extends beyond physical and sexual abuse to also include emotional and economic abuse.[64] For women who are living with HIV/AIDS, it is especially significant to note how acts of domestic violence can affect their health, including their access and adherence to health care, including HIV treatment. Lichtenstein has developed an extended definition of domestic violence to include a number of examples of such violence as a barrier to health care.[65]

The need to factor this HIV-related expansion into our understanding of domestic violence is graphically confirmed by the results of a recent study conducted by Human Rights Watch in Zambia. Women reported to Human Rights Watch that domestic violence at the hands of their husbands and intimate partners, and the fear of such violence, had a direct, harmful impact on their ability to start and continue using ART.[66] Women said that they were beaten, slapped, shouted at, verbally abused, and raped upon discussing HIV testing and treatment with their husbands, after disclosing their HIV status to their husbands, and as a result of visiting health facilities to collect their ART. Some of the women interviewed by Human Rights Watch researchers recounted that they could not be tested for HIV infection or get access to ART because of abuse or fear of abuse.

Furthermore, some women only accessed HIV services and started ART after their husbands died. Others said that they received HIV tests through antenatal services while pregnant, but because of violence and the fear of violence they did not go back to the health facility to collect their test results. Yet other women started taking ART without informing their husbands.[67]

The implications of having to take ART in secret are far-reaching. In some instances, this resulted in interviewees missing doses or failing to collect medication from clinics.[68] Women had to come up with ingenious hiding-places for pills and medication[69] and invent excuses to explain away the side-effects of ART. The consequences of failure to strictly adhere to ART are potentially disastrous, since such adherence to ART must be close to perfect (95 percent) to achieve proper suppression of HIV.[70] Lack of adherence can also lead to the emergence of new, resistant strains of HIV that can both be transmitted to others and lead to drug failure.

In extreme cases, disclosure of a woman's HIV status may even result in her death. In the South African context, there are the examples of Gugu Dlamini, an AIDS activist who was kicked and beaten to death by a group of people following public disclosure of her HIV status,[71] and Lorna Mlofana, killed under tragic circumstances when she was first gang-raped and subsequently beaten to death by the rapists when she informed them that she was HIV positive.[72]

5. The UN Secretary General's Task Force on Women, Girls and HIV/AIDS in Southern Africa

5.1 Background to the establishment of the Task Force

In January 2003, Stephen Lewis, the former Special Envoy on HIV/AIDS in Africa, accompanied by James Morris, Executive Director of the World Food Programme and the UNSG's Special Envoy for Humanitarian Needs in Southern Africa, visited Lesotho, Malawi, Zambia and Zimbabwe in a joint effort to address the unprecedented humanitarian crisis in southern Africa caused by the inter-linkages between HIV/AIDS, food insecurity and weakened government capacity. Their mission report highlighted the impact of the crisis on the women of southern Africa, stating that "very little is being done to reduce women's risks, to protect them from sexual aggression and violence, to ease their burdens or to support their coping and caring efforts".[73]

The envoys recommended the initiation of "immediate, strongly led and broadly implemented joint effort to take action on gender and HIV/AIDS". The UN Secretary General immediately requested UNICEF Executive Director Carol Bellamy to set up a Task Force to respond to this recommendation.

The Task Force comprised 27 women and men living and working in southern African actively engaged in policymaking, programme implementation and community mobilization.[74] The terms of reference for the Task Force focused on the following six issues within a broad gender framework:[75]

1. Prevention of HIV/AIDS among young women and girls;
2. Girls' education;
3. Violence against women and girls;
4. Property and inheritance rights of women and girls;
5. The role of women and girls in caring for those infected and affected by HIV/AIDS; and
6. Access to HIV/AIDS care and treatment for women and girls.

The work of the Task Force focused on the nine countries in southern Africa most severely affected by HIV/AIDS: Botswana, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Zambia and Zimbabwe.[76] Members visited each country, accompanied by colleagues from bodies such as

UNAIDS and WHO, to conduct rapid assessments of the situations and of existing initiatives and actions on gender and HIV/AIDS, and to gather concrete suggestions for action. Country visits were followed by a regional consultation of Task Force members to review what was learnt from the rapid assessments and reach consensus on the way forward.[77]

The findings of the Task Force show that gender inequality fuels HIV infection because many women and girls cannot negotiate safer sex or turn down unwanted sex.[78] The findings also demonstrate that HIV/AIDS deepens and exacerbates women's poverty and inequality because it requires them to do more domestic labour as they care for the sick, the dying and the orphaned.

5.2 Findings on violence against women

Regarding the context of gender-based violence in southern Africa, the Task Force report explains that the high levels of violence in this subregion are often attributed to the legacy of recent civil wars and of apartheid, which had a destabilizing effect beyond the borders of South Africa.[79] This legacy intersects with the legacy of colonialism and indigenous patriarchy to operate in powerful ways to the detriment of women.

When it comes to *domestic violence*, the full extent of the problem in southern Africa is difficult to measure as most countries do not collect statistics on domestic violence.[80] However, the studies and surveys that have been done (for instance, in Zimbabwe and South Africa), point to high levels of violence. Evidence further suggests that domestic violence is so endemic and normalized that women themselves often believe that wife beating is acceptable.[81]

The Task Force also found that high levels of *sexual violence* are reported in the sub-region, with teenage girls and younger women particularly at risk.[82] Again, as with domestic violence, women

and girls may be blamed for sexual violence. 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.

The issue of *marital rape* is a particularly thorny one across the sub-region.[83] Judicial officials in Botswana and Malawi reportedly said that husbands cannot rape their wives as consent to sex is given upon marriage. 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, such as in South Africa, justice can remain elusive.[84]

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 criminalising sexual violence and domestic violence.[85] It was clear from country visits that police officers, prosecutors, magistrates, judges and other judicial officers rarely receive the training they require to handle violence cases sensitively.

The report notes that many women stay in abusive relationships because they cannot afford to leave.[86] 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 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.

On the positive side, the Task Force points out that in all countries where legislation addressing

gender-based violence has been enacted, there has been an increase in the reporting of rape and sexual assault.[87] Several countries have specialized units dealing with domestic violence and sexual abuse of women and children, and these units are increasingly including counseling and access to emergency health services and referrals in their services. In a number of Task Force countries (such as Botswana, Namibia and Zambia) organisations are testing "one-stop" facilities, which are already widely available in South Africa.[88] The report also hails the growing involvement of men in the struggle to end violence against women as a positive development.

6. The Role of SADC

The Southern African Development Community was established in 1992,[89] in recognition of the need for states in the subregion to unite in order to strengthen themselves economically and politically and to promote peace and security.[90] The objectives of the Community, set out in Article 5 of the SADC Treaty, were expanded in 2001 to include the following:

- combatting HIV/AIDS and other deadly or communicable diseases;
- ensuring that poverty eradication is addressed in all SADC activities and programmes; and
- mainstreaming gender in the process of community building.

The revision and expansion of the SADC Treaty in 2001 was accompanied by significant changes in the SADC structure. In addition to the establishment of four Directorates,[91] a Department of Strategic Planning, Gender and Development and Policy Harmonisation was instituted.[92] The Gender Unit in this Department is *inter alia* responsible for advising on matters pertaining to gender

mainstreaming, and also deals with violence against women.[93] Furthermore, an HIV and AIDS Unit forms part of this Department, with the mandate of leading, coordinating and managing the SADC response to the epidemic through the operationalisation of the *HIV and AIDS Strategic Framework (2003-2007)* and the *Maseru Declaration.*[94]

The 2001 restructuring of SADC further necessitated the drafting of a comprehensive strategic plan, and a realigned *Regional Indicative Strategic Development Plan* (RISDP) was accordingly adopted.[95] The RISDP, which aims to provide SADC Member States with a coherent and comprehensive development agenda on social and economic policies over fifteen years,[96] identifies a number of priority intervention areas. These priority areas include certain cross-sectional or cross-cutting issues, with HIV/AIDS and gender equality both identified among these cross-cutting intervention areas.

The RISDP sets out that the overall goal of SADC HIV and AIDS intervention is to decrease the number of HIV and AIDS infected and affected individuals and families in the SADC region so that HIV and AIDS is no longer a threat to public health and to the socio-economic development prospects of Member States.[97] In terms of gender equality and development, the overall goal is to facilitate the achievement of substantive equality between women and men in the SADC region, through mainstreaming gender into all national and regional policies, programmes and activities, and the adoption of positive measures to accelerate progress in this regard.[98] One of the strategies identified for achieving this goal is the reduction and eventual eradication of all forms of violence against women and children.

1   This number appears to show significant declines in the estimated numbers of persons living with HIV in 2007, and seems to represent a reduction of 16% compared with the estimate published in 2006. However, the 2007 Update report explains that these changes in the estimates are the result of advances in the "methodology of estimations of HIV epidemics applied to an expanded range of country data". Importantly, the qualitative interpretation of the severity and implications of the pandemic has altered little. It is emphasized that these differences between estimates published in 2006 and those published in 2007 result largely from refinements in methodology, rather than trends in the pandemic itself. The single biggest reason for the reduction in the estimated number of persons living with HIV worldwide was a reassessment of India's epidemic, with a concomitant revision of the country's estimates. There were also important revisions of estimates elsewhere, particularly in sub-Saharan Africa, which contributed to the overall reduction. Seventy percent of the difference in the estimates published in 2006 and 2007 are due to shifts in six countries, ie Angola, India, Kenya, Mozambique, Nigeria and Zimbabwe – see UNAIDS & WHO *AIDS Epidemic Update* (2007) at 15.

2   UNAIDS & WHO (above) at 7; 15.

3   (Above) at 8.

4   (Above) at 15.

5   (Above) at 15.

6   (Above) at 16.

7   (Above) at 17.

8   This table was compiled based on information from UNAIDS & WHO *AIDS Epidemic Update* (2007) as 16-20 as well as from UNAIDS website resources where indicated.

9   See UNAIDS Country Website for Mauritius - [www.unaids.org/en/CountryResponses/Countries/mauritius.asp].

10 Report of the Secretary-General *Declaration of Commitment on HIV/AIDS: Five Years Later* (24 March 2006) Ref: A/60/736 at Par 1. The 2001 Special Session and the follow-up process in 2006 are discussed in more detail in Section 3 below.

11 Report of the Secretary-General (above) Par 2.

12 UNAIDS & WHO *Report on the Global AIDS Epidemic* (2006) at 80.

13 The Human Development Index (HDI) is a composite indicator covering three dimensions of human welfare, ie income, education, and health. Its purpose is not to give a complete picture of human development, but to provide a measure that goes beyond income. The HDI is a barometer for changes in human well-being and for comparing progress in different regions – UNDP *Human Development Report - International Cooperation at a Crossroads: Aid, Trade and Security in an Unequal World* (2005) at 21.

14 The former Soviet Union accounts for the other six countries registering lower HDI scores – UNDP (above) at 21.

15 This table was compiled based on information provided in UNDP *Human Development Report 2007/ 2008 – Fighting Climate Change: Human Solidarity in a Divided World* (2007) at 229 et seq.

16 M O'Grady "The impoverishing pandemic: the impact of the HIV/AIDS crisis in southern Africa on development" in *Development Update - From Disaster to Development: HIV and AIDS in Southern Africa* (December 2004) Vol 5 No 3 at 21.

17 UNAIDS & WHO *Report on the Global AIDS Epidemic* (2006) at 81-82.

18 UNAIDS & WHO (above) at 82-83.

19 F Kalibwani *Food Security in Southern Africa* (2005) at 13.

20 Kalibwani (above) at 13; UNDP *Human Development Report* (2005) at 22.

21 According to Panagides, in South Africa an estimated 35% of the population (or 14 million people) are vulnerable to food insecurity. Forty-three percent of households suffer from food poverty – where monthly food spending is less than the cost of a nutritionally adequate diet. See D Panagides et al *A Review of Nutrition and Food Security Approaches in HIV and AIDS Programmes in Eastern and Southern Africa* (2007) at 5; also O'Grady (above) at 36-37.

22 R Menon *Famine in Malawi: Causes and Consequences* (2007) at 1.

23 This section is based on H Combrinck & L Wakefield *Haunted Houses: Domestic Violence and HIV/AIDS* (2007) Unpublished research report produced for the Law, Race and Gender Research Unit, University of Cape Town.

24 Amnesty International *Women, HIV/AIDS and Human Rights* (2004) at 2.

25 UNAIDS & WHO *AIDS Epidemic Update* (2007) at 8.

26 (Above) at 8.

27 U Kistner *Gender-based violence and HIV/AIDS in South Africa* (2003) at 18; Amnesty International (above) at 3; UNAIDS et al *Women and HIV/AIDS: Confronting the Crisis* (2004) at 8; UN Special Rapporteur on Violence Against Women, Its Causes and Consequences *The Intersections of Violence Against Women and HIV/AIDS* (17 January 2005) Ref E/CN.4/2005/72 at Par 21.

28 Amnesty International (above) at 3.

29 UNAIDS et al *Women and HIV/AIDS* (2004) at 2.

30 Amnesty International (above) at 3. See also L Vetten & K Bhana *Violence, Vengeance and Gender* (2001) at 5.

31 This practice is described as follows: "Some women use herbs, roots and even bleach, vinegar and snuff to dry out their vaginal secretions to tighten the vagina. This is believed to increase male pleasure during sex. However, penetrative sex under such conditions can cause cuts to the vagina, which makes it easier for HIV to pass into the bloodstream." – Soul City et al *HIV/ AIDS: A Resource for Journalists* (undated) 32-33.

32 Vetten & Bhana (above) at 5; see also J Campbell 'Health consequences of intimate partner violence' *The Lancet* (2002) 1331 at 1332; World Health Organisation *World Report on Violence and Health* (2002) at 163.

33 O'Grady (above) at 34.

34 Human Rights Watch *Suffering in Silence: The Links Between Human Rights Abuses and HIV Transmission to Girls in Zambia* (2002) at 13.

35 Human Rights Watch (above) at 13.

36 See also Amnesty International (above) at 2; UN Special Rapporteur (above) at Par 21.

37 It has been said that some men may interpret the payment of lobola to mean that their wives are now their property, to do with as they please since they have been 'paid for'. Women may therefore have less power in sexual decision-making and are not allowed to refuse their husbands sex. Polygyny legitimises the notion that men should have access to multiple sexual partners – see Vetten and Bhana (above) at 6.

38 O'Grady (above) at 35.

39 ILO *HIV/AIDS and Work: Global Estimates, Impact and Response* (2004) at 170 cited in O'Grady (above) at 35.

40 Many of the Zambian women interviewed by Human Rights Watch said they were counseled upon reaching puberty to be submissive and obey their future husbands - Human Rights Watch *Hidden in the Mealie Meal: Gender-Based Abuses and Women's HIV Treatment in Zambia* (2007) at 24.

41 (Above) at 24.

42 T Jacobs *Domestic Violence and HIV/AIDS: An Area for Urgent Intervention* (2003) at 3.

43 Jacobs (above) at 3; UNAIDS et al *Women and HIV/AIDS* (2004) at 8.

44 Report of UN Secretary-General Task Force on Women, Girls and HIV in Southern Africa *Facing the Future Together* (2004) at 9-10.

45 Amnesty International (above) at 4. See also Human Rights Watch *Hidden in the Mealie Meal: Gender-Based Abuses and Women's HIV Treatment in Zambia* (2007) at 9.

46 Amnesty International (above) at 5.

47 Report of the Secretary-General *Declaration of Commitment on HIV/AIDS: Five Years Later* (2006) at Par 160.

48 (Above) at Par 160.

49 Report of UN Secretary-General's Task Force on Women, Girls and HIV in Southern Africa (above) at 20. See also discussion below.

50 Amnesty International (above) at 4. See also Human Rights Watch *Just Die Quietly: Domestic Violence and Women's Vulnerability to HIV in Uganda* (2003) at 22.

51 K Dunkle et al "Gender-based violence, relationship power, and risk of HIV infection in women attending antenatal clinics in South Africa" *The Lancet* (2004) at 1419. An earlier study in Tanzania found that HIV positive women were 2.68 times more likely to have experienced a violent episode by a current partner – S Maman et al "HIV-Positive women report more lifetime partner violence: Findings from a voluntary counseling and testing clinic in Dar Es Salaam, Tanzania" *American Journal of Public Health* (2002) at 1334 ; see also R Jewkes et al "Factors associated with HIV sero-status in young rural South African women: Connections between intimate partner violence and HIV" *International Journal of Epidemiology* (2006) at 1467.

52 UNAIDS et al (above) at 7.

53 Amnesty International (above) at 6.

54 Human Rights Watch (above) at 9.

55 See also C Johnson Welch et al *Women's Property Rights as an AIDS Response: Lessons from Community Interventions in Africa* (2007) at 5,7.

56 See also Dunkle et al (above) at 1415; UN Special Rapporteur on Violence Against Women *Towards An Effective Implementation of International Norms to End Violence Against Women* (2004) Un Doc E/CN.4/2004/66 dated 26 December 2003 at Par 48.

57 SADC *Expert Think Tank Meeting on HIV Prevention in High Prevalence Countries in Southern Africa - Report* (2006) at 3. See also N Andersson et al "Risk factors for domestic physical violence: National cross-sectional household surveys in eight southern African countries" *BMC Women's Health* (2007).

58 Epidemiologists have observed that in Africa men and women often have more than one – typically two or perhaps three – concurrent partnerships that can overlap for months or years. A comparison (using mathematical modeling) of the spread of HIV in two populations, one in which serial monogamy was the norm and one in which long-term concurrency was common, showed that HIV transmission was much more rapid with long-term concurrency. Significantly, the epidemic predicted for the latter

population was 10 times greater. Halperin and Epstein explain that viral load, and thus infectivity, is much higher during the "acute infection" window period (typically about 3 weeks long), initially following HIV infection. The combined effects of sexual networking and the acute infection spike in viral load means that as soon as one person in a network of concurrent relationship contracts HIV, everyone else in the network is placed at risk. See D Halperin & H Epstein "Why is HIV prevalence so severe in southern Africa?" *The Southern African Journal of HIV Medicine* (2007) at 20.

59 Three randomized controlled studies undertaken in South Africa, Kenya and Uganda have concluded that male circumcision reduces the risk of acquiring HIV by a man from his female partner by 50 – 60% - see SADC *Towards Universal Access to HIV Prevention: SADC Strategic Action Plan 2008-2010* (August 2007) at 13. Although there is a correlation between circumcision and reduced risk of acquiring HIV, circumcised men can still be infected with HIV and still need to continue using condoms, reduce their numbers of sex partners and treat STIs if they are to benefit from the additional protective benefits of male circumcision. As a relatively new intervention in the context of HIV prevention there is limited information on it. See also Viljoen & Precious *Human Rights Under Threat* (2007) at 1-2.

60 Amnesty International (above) at 6.

61 Amnesty International (above) at 6; UNAIDS et al *Women and HIV/AIDS* (2004) at 7; UN Special Rapporteur UN Special Rapporteur on Violence Against Women, Its Causes and Consequences *The Intersections of Violence Against Women and HIV/ AIDS* (17 January 2005) Ref E/CN.4/2005/72 at Par 29.

62 R Jewkes et al (above) at 1462.

63 UNAIDS et al *Women and HIV/AIDS* (2004) at 45. See also UN Special Rapporteur (above) at Par 62-63; Vetten & Bhana (above) at 23. See in this regard also A Strebel et al "Social construction of gender roles, gender-based violence and HIV/AIDS in two communities of the Western Cape, South Africa" *Journal of Social Aspects of HIV/AIDS* (2006) at 522. Campbell also reports on studies showing that requests for condom use, HIV testing or notification of positive HIV status may result in abusive incidents, often with accusations of infidelity – (above) at 1332.

64 See section 1 of the South African Domestic Violence Act 116 of 1998 and the definitions of the different forms of "domestic violence" set out there.

65 B Lichtenstein "Domestic violence in barriers to health care for HIV-positive women" *AIDS Patient Care and STD's* (2006) at 125-126.

66 See Human Rights Watch *Hidden in the Mealie Meal: Gender-Based Abuses and Women's HIV Treatment in Zambia* (2007) at 21-29. The experiences described by the interviewees are directly in line with the examples provided by Lichtenstein.

67 Human Rights Watch (above) at 22.

68 Human Rights Watch (above) at 25-27.

69 Hence the title of the Human Rights Watch report.

70 Human Rights Watch (above) at 80.

71 For a detailed description of the case, see M Mbali "HIV/AIDS and gender-based violence crime in South Africa" in L Davis & R Snyman (eds) *Victimology in South Africa* (2005) at 266.

72 Mbali (above) at 267. One of the rapists was subsequently convicted of murder and rape, and sentenced to life and 10 years' imprisonment on the two counts (to be served concurrently). A woman who had participated in the beating was convicted of assault, and her sentence was one of ten years' imprisonment, with three years suspended - Anon "Treatment Action Campaign welcomes sentence in Lorna Mlofana trial" *Treatment Action Campaign Electronic Newsletter* (16 February 2006). Accessed at www.tac.org.za/newsletter/2006/ns16_02_2006_2.html.

73 Report of UN Secretary-General Task Force on Women, Girls and HIV in Southern Africa *Facing the Future Together* (2004) at 3.

74 Task Force Report (above) at 4.

75 Task Force Report (above) at 3.

76 Task Force Report (above) at 4.

77 Task Force Report (above) at 4.

78 Task Force Report (above) at 5.

79 Task Force Report (above) at 29.

80 Task Force Report (above) at 29. It is interesting to compare the findings of the Task Force with the results of the research subsequently conducted by Andersson et al on (physical) domestic violence in eight southern African countries, both in terms of the numbers of respondents who reported having experienced domestic violence and in terms of the attitudinal aspects reported to researchers. See Andersson et al (above).

81 Task Force Report (above) at 29-30. For example, a study conducted in Lesotho by the 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.

82 Task Force Report (above) at 30.

83 Task Force Report (above) at 31.

25

84 Task Force Report (above) at 31.

85 Task Force Report (above) at 31.

86 Task Force Report (above) at 32.

87 Task Force Report (above) at 33.

88 According to the report, such facilities should allow women to access in a single location all the services they require in cases of domestic violence of sexual assault, including police officers, social workers, counselors and health workers who can dispense PEP.

89 The Windhoek Declaration and Treaty for the Establishment of the Southern African Development Community was adopted on 17 August 1992 by the states formerly constituting the Southern African Development Co-ordination Conference [SADCC]. The SADCC was founded in 1980. For an overview of the establishment and development of SADCC, see SADC *Regional Indicative Strategic Development Plan* (2001) at 1-2.

90 C Warioba & AG Luhanga "SADC initiatives aimed at combating gender-based violence" in E Delport (ed) *Gender-Based Violence in Africa* (2007) at 32.

91 Trade, Industry, Finance and Investment; Food, Agriculture and Natural Resources; Social and Human Development and Special Programmes; Infrastructure and Services - SADC *SADC HIV and AIDS Strategic Framework and Programme of Action 2003-2007* (July 2003) at 18.

92 Warioba & Luhanga (above) at 34.

93 SADC Website "Gender Unit: Overview". Accessible at www.sadc.int/odes/gender/index.php.

94 SADC *SADC HIV and AIDS Business Plan* (2004) at 12.

95 Most of the pre-existing policies, strategies and programmes of SADC had been designed independently by individual Sector Coordinating Units before the latter were grouped into directorates. For this reason, the various policies and strategies were not properly co-ordinated, leading to weak intersectoral linkages - SADC *Regional Indicative Strategic Development Plan* (2001) [hereinafter referred to as 'RISDP'] at 7.

96 SADC *RISDP* at 7.

97 SADC *RISDP* at 57.

98 SADC *RISDP* at 58.

SECTION 3: POLITICAL COMMITMENTS

1. Introduction

Since 2000, governments in southern Africa have participated in a number of initiatives where they have committed themselves to addressing gender inequality, gender-based violence and HIV/AIDS. In this section, we provide a brief overview of selected government undertakings in this regard. Because of the number of initiatives on international and regional (African) level, it is not possible to include all in detail here.[1]

We commence with a brief exposition of the *UN Millennium Development Goals*, since these goals and their related targets are often used as benchmarks and points of reference in subsequent documents. We then look at the *2001 Abuja Declaration on HIV, Tuberculosis and Other Infectious Diseases*, and subsequently examine the *2001 UN General Assembly Special Session on AIDS* in some detail. The focus next shifts to the *2003 Maseru Declaration*; this is followed by an examination of the *Brazzaville Commitment*, the *2006 Abuja Call for Action* and the *2006 Follow-up on the UN Declaration of Commitment*. The section concludes with a discussion of the draft *SADC Protocol on Gender and Development*.

It should be noted that in our analysis, we focus on how the issues of gender, gender-based violence and HIV/AIDS are expressly dealt with in each document. This is to some extent an incomplete inquiry, since the majority of these documents also contain undertakings (such as commitments to improve the public health care system or to commit additional budgetary resources to HIV prevention) that should *indirectly* hold benefits for women. It is recommended that readers consult the texts of the relevant documents in this regard.

2. UN Millennium Development Goals

One of the first noteworthy events for purposes of our analysis was the UN Millennium Summit in September 2000, where world leaders endorsed eight Millennium Development Goals (MDG's) in order to combat hunger, poverty, disease, illiteracy and environmental degradation on a global scale.[2] Specific targets were also set to ensure measurable progress.

The sixth Millennium Development Goal is to combat HIV/AIDS, malaria and other diseases, and one of the targets is to have halted by 2015 and begun to reverse the spread of HIV/AIDS. The third Millennium Development Goal is to promote equality and empower women. The target set here is to eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015.[3]

Apart from the self-evident significance of these two goals in the context of a discussion on gender-based violence and HIV/AIDS, it is further important to note that several of the documents discussed below incorporate references to the MDG's. There are also alignments between monitoring progress in achievement of the MDG's and of the objectives of other documents, such as the *UNGASS Declaration of Commitment* (2001).[4]

3. Abuja Declaration (2001)

During 26-27 April 2001, the African heads of state and government of the OAU met in Abuja, Nigeria, at a special summit convened to address the challenges posed by HIV/AIDS, tuberculosis and malaria in Africa. This summit followed previous initiatives such as the *2000 Abuja Summit on Roll Back Malaria*. The summit resulted in the *Abuja Declaration and Plan of Action on HIV/AIDS, Tuberculosis and other Infectious Diseases*.

The participants declared that they considered AIDS to be a state of emergency on the continent,[5] and committed themselves to take all necessary measures to ensure that the needed resources were made available and that they are efficiently and effectively utilised.[6] Importantly, signatories pledged to set a target of allocating at least 15% of their annual budget to the improvement of the

health sector.[7] The document also sets out undertakings in a number of other key areas, such as leadership in the activities of national AIDS bodies[8] and ensuring availability of drugs at affordable prices.[9]

The Declaration further contains the following statement:

"We recognise that biologically, women and girls are particularly vulnerable to HIV infection. In addition, economic and social inequalities and traditionally accepted gender roles leave them in a subordinate position to men."[10]

Significantly, this acknowledgement of the vulnerability of women and girls is included in a section where various groups who are at increased risk of HIV infection, including children, youth and users of injecting drugs, are recognised.[11] Women and girls are therefore not specifically singled out.

4. UN General Assembly Special Session on HIV/AIDS (2001)

During June 2001, a special session of the UN General Assembly on HIV/AIDS was called as a result of concern about the accelerating pandemic and its global impact. The aim was to intensify international action against HIV/AIDS and to mobilize the required resources. One of the outcomes of this special session was the adoption by the General Assembly of the *Declaration of Commitment on HIV/AIDS*.[12]

4.1 Declaration of Commitment on HIV/AIDS

The Declaration starts with a general introductory section, which sets out the broad context and impact of the pandemic. It is significant that this impact is placed in both a human rights and developmental framework:

"... [T]he global HIV/AIDS epidemic, through its devastating scale and impact, constitutes a global emergency and one of the most formidable

challenges to human life and dignity, as well as to the effective enjoyment of human rights, which undermines social and economic development throughout the world and affects all levels of society – national, community, family and individual..."[13]

The introduction also notes that while all people, rich and poor, "without distinction as to age, gender or race", are influenced by the HIV/AIDS epidemic, people in developing countries are the most affected. It further acknowledges the specific vulnerability of women, young adults and children, in particular girls.[14] The Declaration stresses that gender equality and the empowerment of women are fundamental elements in the reduction of this vulnerability of women and girls to HIV/AIDS.[15]

It is further pointed out that Africa, in particular sub-Saharan Africa, is currently the worst-affected region, where HIV/AIDS is considered a state of emergency threatening development, social cohesion, political stability, food security and life expectancy and imposing a devastating economic burden.[16] This dramatic situation on the continent needs urgent and exceptional national, regional and international action. The signatories accordingly welcome the commitments of African heads of state and government at the Abuja special summit in 2001, particularly their pledge to set a target of allocating at least 15% of their annual national budget for the improvement of the health sector to help address the HIV/AIDS epidemic.[17] However, it is recognized that in the case of countries whose resources are limited, action to reach this target will need to be complemented by increased international assistance.

The *Declaration of Commitment* then addresses ten key focus areas, with specific targets and timeframes for each. These focus areas are:
- leadership;
- prevention;
- care, support and treatment;
- respect for human rights;

- reducing vulnerability;
- children orphaned and made vulnerable by HIV/AIDS;
- alleviating social and economic impact;
- research and development;
- HIV/AIDS in conflict and disaster-affected regions; and
- resources.

In the section below, we briefly describe where the Declaration pays attention to gender in the specific focus areas.[18]

In terms of *leadership*, national governments are required (by 2003) to ensure the development and implementation of multisectoral national strategies and financing plans for combating HIV/AIDS that (inter alia) address the gender and age-based dimensions of the epidemic and involve the full participation of those in vulnerable groups and people mostly at risk, particularly women and young people.

When it comes to *prevention*, specific attention is paid to the age group of young persons aged 15-24.[19] States are expected, by 2003, to establish time-bound national targets to achieve the internationally agreed global prevention goal to reduce by 2005 HIV prevalence among young men and women aged 15 to 24 in the most affected countries by 25% and by 25% globally by 2010, and intensify efforts to achieve these targets as well as to challenge gender stereotypes and attitudes, and gender inequalities in relation to HIV/AIDS, encouraging the active involvement of men and boys.[20] They are further required, by 2005, to ensure that at least 90%, and by 2010 at least 95%, of young men and women aged 15 to 24 have access to the information, education and services necessary to develop the life skills required to reduce their vulnerability to HIV infection.[21] This focus area also sets targets regarding the prevention of mother-to-child-transmission of HIV.[22]

In the context of *promoting respect for human rights*, states must, by 2005, develop and acceler-ate the implementation of national strategies that promote the advancement of women and women's full enjoyment of all human rights - bearing in mind the context and character of the epidemic and that, globally, women and girls are disproportionately affected by HIV/AIDS.[23] They are expected to promote shared responsibility of men and women to ensure safe sex, and to 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.

By 2005, states must furthermore implement measures to increase capacities of women and adolescent girls to protect themselves from the risk of HIV infection, principally through the provision of health care and health services, including for sexual and reproductive health, and through prevention education that promotes gender equality within a culturally and gender-sensitive framework.[24] In addition, they must, by 2005, ensure development and accelerated implementation of national strategies for women's empowerment, the promotion and protection of women's full enjoyment of all human rights and reduction of their vulnerability to HIV/AIDS through the elimination of all forms of discrimination, as well as all forms of violence against women and girls, including harmful traditional and customary practices, abuse, rape and other forms of sexual violence, battering and trafficking in women and girls.[25]

In terms of *reducing vulnerability*, states must, by 2003, in order to complement prevention programmes that address activities placing individuals at risk of HIV infection, such as risky and unsafe sexual behaviour, have in place in all countries strategies, policies and programmes that identify and begin to address those factors that make individuals particularly vulnerable to HIV infection, including (amongst others), economic insecurity, poverty, lack of empowerment of women, lack of information and/ or commodities for self-protection, and all types of sexual exploi-

tation of women, girls and boys.[26] Such strategies should address the gender dimension of the epidemic, specify the action that will be taken to address vulnerability and set targets for achievement.

In the area of **alleviating social and economic impact**, the commitments undertaken by states include, by 2003, to review the social and economic impact of HIV/AIDS at all levels of society, especially on women and the elderly, particularly in their role as caregivers, and in families affected by HIV/AIDS, and address their special needs.[27]

The Declaration is significant in that it clearly acknowledges the importance of gender equality and the empowerment of women in reducing the vulnerability of women and girls to sustaining HIV, and introduces this gender dimension in several of the ten key focus areas. Governments are specifically encouraged to ensure that this gender aspect is addressed in the formulation of national strategies and prevention programmes. Furthermore, the elimination of violence against women is emphasized as an aspect of promoting respect for human rights.

5. Maseru Declaration on HIV and AIDS

In July 2003, the SADC heads of state and government met in Maseru, Lesotho, for a subregional summit on HIV/AIDS. On this occasion, the *Maseru Declaration on the Fight Against HIV and AIDS in the SADC Region* was adopted.

The Declaration states that the "principal contributory factors to the spread of HIV/AIDS are extreme poverty, ignorance, negative attitudes and practices" and that the general underdevelopment and unfavourable international economic environment reflected in high indebtedness of some of the SADC member states, limited access to international markets and declining official development assistance, further aggravate the pandemic.[28] It also recognizes that inadequate food security, poor nutrition, inadequate essential public services,

limited reproductive health services, gender imbalances and high levels of illiteracy impact negatively on the quality of life of people living with HIV and AIDS.[29]

The Declaration observes that the HIV and AIDS pandemic can be curbed, and that within the SADC region there have been some successes and best practices in changing behaviour, reducing new HIV infections and mitigating the impact of the HIV and AIDS pandemic, and that these successes need to be rapidly scaled up and emulated across the region. It notes that HIV and AIDS is best tackled through multi-sectoral interventions aimed at poverty eradication, which include the promotion of socio-economic development, fostering positive cultural attitudes and practices, gender equity, and undertaking specific health and nutritional interventions as well as programmes to combat the abuse of alcohol and illicit drugs.[30]

The participants reaffirmed their commitment to the combating of the AIDS pandemic in all its manifestations through multi-sectoral strategic interventions as contained in the *SADC HIV and AIDS Strategic Framework and Programme of Action (2003-2007)*. Five priority areas are declared for urgent attention and action, ie –

- prevention and social mobilization;
- improving care, access to counseling and testing services, treatment and support;
- accelerating development and mitigating the impact of HIV and AIDS;
- strengthening institutional, monitoring and evaluation mechanisms; and
- intensifying resource mobilization.

Specific gender-related initiatives are included in certain of the five priority areas, although perhaps not as many as one would have expected (especially in the wake of the 2001 *UN Declaration of Commitment*). For example, in terms of **prevention and social mobilization**, member states undertake to strengthen initiatives that would increase the capacities of women and adolescent girls to protect

themselves from the risk of HIV infection, principally through the provision of health care and health services, including for sexual and reproductive health and through prevention education that promotes gender equality within a culturally and gender sensitive framework.[31] They are also required to rapidly scale up the programmes for PMTCT of HIV, and to ensure that levels of uptake are sufficient to achieve the desired public health impact.[32] In order to **accelerate development and mitigate the impact of HIV and AIDS**, member states are expected to create and sustain an enabling environment conducive to gender-balance, rapid and broad-based socio-economic development of the region and address major underlying factors that lead to the spread of the HIV infection.[33]

Importantly, the Declaration paves the way for the *SADC HIV and AIDS Strategic Framework and Programme of Action (2003-2007)* in that member states, for example, commit themselves to the establishment of a regional fund for the implementation of the Framework.[34] They also undertake to develop and strengthen appropriate mechanisms for monitoring and evaluating the implementation of this Declaration and other continental and global commitments, and establishing targets and time-frames that will be included in the Strategic Framework.[35]

6. Brazzaville Commitment on Scaling Up Towards Universal Access (March 2006)

In March 2006, the AU (with the support of *inter alia* UNAIDS and WHO) convened a continental consultation on scaling up towards universal access to HIV/ AIDS prevention, treatment, care and support in Africa. This meeting was attended by more than 250 participants from the 53 member states of the AU, including health ministers, government representatives, parliamentarians, national AIDS councils, faith-based organisations, civil society organisations and people living with HIV.[36]

The document that was the outcome of the three-day consultation, the *Brazzaville Commitment on Scaling Up Towards Universal Access to HIV and AIDS Prevention, Treatment, Care and Support in Africa by 2010*, was presented to the AU Special Summit in Abuja, Nigeria, and constituted Africa's contribution to the 2006 United Nations Summit on AIDS, which took place in June.[37]

The participants in the consultation firstly recognized the vital and ongoing contribution of individuals, communities and governments to the fight against HIV/AIDS.[38] They acknowledged that this occurs "in a reality framed by deep and persistent poverty, food insecurity, indebtedness, economic constraints, youth unemployment, gender inequality, gender-based violence, conflicts, natural disasters, ignorance, fear, stigma and discrimination".[39] The participants confirmed that they are ever mindful of the disproportionate share and severe impact of the HIV/AIDS burden borne by Africa, especially by women and girls, and of the limitations in their ability to match the epidemic in either its scale or complexity.[40]

The participants identified the following as some of the main obstacles to rapid and sustainable scale-up of existing national programmes and services:

- A very high dependence on external funds that are unpredictable and often subject to excessive conditions. This is compounded by insufficient allocation of national resources, due in part to debt servicing, and uneven distribution of resources by sector, geographic region and thematic area.[41]
- Weak health systems and delivery services, including human resources and infrastructures.
- Inadequate coordination, lack of good governance, weak management and monitoring and evaluation systems across all sectors, which affect service delivery, oversight and accountability.
- The high vulnerability of women and girls,

which is not adequately addressed through existing legal and programmatic measures.

Participants recommended a number of urgent actions to overcome these obstacles to universal access. The actions are dealt with under **seven** themes, ie financing; human resources and systems; building and strengthening systems; affordable commodities, technology and essential medicines; human rights and gender; and fostering accountability.

Under the theme **human rights and gender**, participants recommend the following actions (amongst others):

(a) Reduce stigma and discrimination through social mobilization, using government, media, educational, community and religious leaders and increase the visibility, involvement and empowerment of people living with HIV and other vulnerable groups. Encourage sharing of best practice.[42]

(b) Support people to exercise their right to know their HIV status without fear of discrimination and expand opportunities for counseling and testing and access to ARV's, while preserving confidentiality.[43]

(c) Promote a supportive environment, including enacting or repealing laws and policies related to gender and human rights, and strengthening implementation of relevant laws, jurisdictions and policies, in line with the AU framework on human rights and HIV/AIDS.[44]

(d) Promote legal and programmatic measures to address the high vulnerability of women and girls.[45]

The *Brazzaville Commitment*, with its theme of scaling up towards universal access, again emphasises the broader contextual framework within which efforts to halt the AIDS pandemic take place, which includes poverty, gender inequality, gender-based violence, stigma and discrimination. The document identifies the main

obstacles to scaling up of programmes and services, and particularly notes that one of these obstacles, ie the high vulnerability of women and girls, is not adequately addressed through existing legal and programmatic measures. Among the actions recommended for overcoming these challenges, are several relating to human rights that either specifically relate to women or have a high degree of relevance for women, such as reducing stigma and discrimination.

7. Abuja Call for Accelerated Action (May 2006)

Abuja, Nigeria, saw a second gathering of the AU heads of state and government from 2 to 4 June 2006 for a special summit on HIV/AIDS, tuberculosis and malaria. The theme of this summit was "Universal Access to HIV/AIDS, Tuberculosis and Malaria Services by a United Africa by 2010", and one of the main objectives was to review the progress made in implementing the *Abuja Declaration and Plan of Action on Roll Back Malaria (RBM) of 2000* and the *Abuja Declaration and Plan of Action on HIV/AIDS, Tuberculosis and Other Infectious Diseases of 2001*. A second objective was to prepare Africa's Common Position for the UN General Assembly Special Session on AIDS.[46] The *Abuja Call for Accelerated Action Towards Universal Access to HIV and AIDS, Tuberculosis and Malaria Services in Africa*[47] was adopted at this summit.

By means of introduction, the document reviews progress made towards achievement of the Abuja Declarations of 2000 and 2001. Participants noted that progress has been observed in the proportion of national budgets allocated to health.[48] Thirty three percent of countries have allocated at least 10% of their national budget to health, while one country has attained the target of 15%.[49] Heads of state have also engaged with the G8 countries for additional resources and debt relief.

Similar to the *Brazzaville Commitment*, the participants in the *Abuja Call* identified the main challenges and obstacles to accelerated action to universal access to HIV/AIDS, tuberculosis and malaria services in Africa to include the following:[50]

ℵ The difficulty in ensuring predictable and sustainable financing for HIV, tuberculosis and malaria services;

ℵ Weak planning, partly because of lack of institutional and human resource capacity at national level;

ℵ Failure to take into account the links between HIV/AIDS and sexual and reproductive health;

ℵ Stigma, discrimination and gender inequity, which result in inadequate application of the human rights of people infected or affected by HIV/AIDS and directly affects their ability to access services; and

ℵ Poor or inadequate coordination of regional and national and international partnerships.

The participants accordingly confirmed that they still consider AIDS, tuberculosis and malaria as a state of emergency on the continent, and they reaffirmed their commitment to the goals set out in the previous *Abuja Declarations*, the *Millennium Development Goals*, the *Brazzaville Commitment*[51] and other documents.[52] They then undertook specific actions in terms of each of the areas of priority identified in the 2001 Abuja Declaration.

Under **the protection of human rights**, the participants committed themselves to continue promoting an enabling policy, legal and social environment that advances human rights particularly for women, youth and children, to ensure the protection of people infected and affected by HIV/AIDS, tuberculosis and malaria and to reduce vulnerability and marginalization.[53] Importantly, they also promise to enact or repeal laws and policies relayed to gender and human rights in order to align them with AU frameworks, including the *Solemn Declaration on Gender Equality in*

Africa and the *African Protocol on Women's Rights*.

In terms of **prevention, treatment, care and support**, participants undertake to invest heavily in evidence-based prevention as the most cost-effective intervention, with a focus on young people, women, girls and other vulnerable groups.[54] Furthermore, they agree to ensure access to a comprehensive package of prevention interventions for the prevention of primary and secondary infections with HIV/AIDS and sexually transmitted infections (STI's) (including post-exposure prophylaxis following sexual violence). They will also integrate HIV/AIDS issues into ongoing immunisation programmes and sexual and reproductive health programmes, and conversely sexually and reproductive health issues into HIV/AIDS programmes. In addition, they commit themselves to ensuring universal access to male and female condoms for all sexually active persons.

The *Abuja Call to Action* addresses Regional Economic Communities, such as SADC, and calls upon them to (inter alia) –

ℵ Intensify the implementation of inter-country and cross-border health initiatives;

ℵ Coordinate inter-country efforts and provide support to member states;

ℵ Mobilise resources for HIV/AIDS, TB and malaria programmes in their respective regions; and

ℵ Report back to the participants through the AU Commission on the progress made in the implementation of this Call.[55]

Finally, the participants requested consultative reviews at two years (2008) and five years (2010) on the status of the *2006 Abuja Call for Action* and of the MDG's.

When comparing the *2001 Abuja Declaration* and the *2006 Abuja Call for Ac*tion, it is clear that significant progress has been made in the years spanning the drafting of the two documents

in terms of developing an understanding of the context of the pandemic in Africa and efforts to combat its spread, including the gendered dimensions.[56] In addition to the inclusion of explicit gender-specific undertakings, such as the alignment of laws and policies with the *AU Solemn Declaration on Gender Equality* and *African Protocol on Women's Rights*, the *Abuja Call for Action* is also important for purposes of this study in that it specifically addresses the Regional Economic Communities.

8. Follow-up to UN Declaration of Commitment on HIV/AIDS (2006)

During 2005-2006, a comprehensive process of review took place to measure progress in realizing the targets set out in the *2001 Declaration of Commitment on HIV/AIDS*. This process entailed the submission of country progress reports based on core indicators developed by UNAIDS to monitor implementation of the Declaration of Commitment.[57]

For the 2006 review, nearly 120 country reports updated the data submitted by countries in 2003, which allowed for identification of trends against the core indicators.[58] These reports were supplemented by additional information from, for example, more than 30 reports compiled by civil society, as well as from national and global surveys.

8.1 SADC Country Reports

In 2006 twelve of the SADC countries fulfilled their duty to submit progress reports as required under the Declaration of Commitment.[59] As a broad overview, it is evident that the majority of the reporting southern African countries do not address gender-based violence as a cause for or a consequence of the high HIV/AIDS prevalence among women.[60]

Certain countries do acknowledge women as a vulnerable group and therefore they regard the high HIV/AIDS prevalence among women as a challenge facing the country.[61] While South Africa and Tanzania mention violence against women, they do not expressly state that this is a reason for the high HIV prevalence among women. Although gender-based violence is not included in any of the core indicators, one would have expected this aspect to feature more strongly, given its prominent role in the underlying framework of the Declaration itself.[62]

8.1.1 South Africa

As part of the overview of the HIV/AIDS situation in South Africa, the South African report recognizes that women (especially black women) for a long time faced oppression with regards to economic, social and political life within the country.[63] It goes further to state that the practical challenges that women face because of these three forms of oppression are violence and abuse, poverty and poor health status.[64] South Africa boasts a number of government-based institutions set up to help combat these forms of oppression and advance the empowerment of women, including the adoption of the Constitution, gender units in each government and deliberate efforts to ensure fair representation of women in decision-making positions in government.[65]

The fact that the South African progress report mentions the struggles women face, and includes violence in the overview of its HIV/AIDS situation, serves as an indication that it tacitly acknowledges gender-based violence as one of the causes of the high HIV prevalence among women. However, the report does not go any further in depth to analyse this violence or provide possible solutions to curb this.

8.1.2 Tanzania

In its 2006 progress report, Tanzania does not recognise women who face violence as part of its "most at risk population".[66] The categories of people who are considered to be "most at risk" include sex

workers, men who have sex with men, injecting drug users, the military and mobile populations.[67] However, the report does give the following example of where a HIV positive mother might face violence from the community and her family:

"... a mother who does not breastfeed her child is discriminated by the community and faces the threat of rejection and domestic violence".[68] Within the report, this is the only documented example of where gender-based violence is seen as a consequence of being HIV-positive.

8.2 UN Secretary-General's Summary Report (March 2006)

A summary report was submitted to the UN General Assembly in March 2006.[69] The report notes that in the five years since 2001, the world has recorded major progress in some key aspects of the global AIDS response, but with inadequate progress on other critical fronts.[70]

"In general, the strengthened global response, while heartening, is nevertheless being rapidly outpaced by the epidemic itself."[71]

Key findings from this report further include the following:[72]

(a) Treatment access has greatly expanded, although efforts have fallen short of global goals. Although the global goals of having 3 million people on ARV treatment by 2005 (the so-called "3 by 5" initiative) was not achieved, this plan did conclusively demonstrate the feasibility of administering ARV drugs in resource-limited settings. By 2006, 1.3 million people in developing countries were benefiting from access to such drugs.[73]

(b) Compared to antiretroviral treatment coverage, which increased threefold between 2003 and 2005, the percentage of pregnant women offered HIV prevention services increased from 8% to 9% in 2005.[74] The overall percentage of HIV-infected pregnant women receiving antiretroviral prophylaxis increased from 3% to 9% in the same period.

(c) A lack of human and institutional capacity is the single biggest obstacle to an effective response to AIDS in many developing countries, particularly in the most heavily affected countries, where the epidemic itself has most dramatically undermined resources.[75]

(d) Stigma and discrimination are key barriers to HIV prevention, treatment and support programmes. Stigma is an especially serious obstacle to the success of HIV prevention programmes, including services for vulnerable populations and for preventing mother-to-child-transmission. Women typically experience the most severe stigma and discrimination.[76]

The report contains a number of key recommendations, including addressing the fundamental drivers of the epidemic.[77] In addition to scaling up prevention and treatment programmes, the report notes that long-term success on AIDS requires that the global community address the factors that increase vulnerability to HIV, such as poverty, illiteracy, economic and gender inequality and all forms of discrimination and social exclusion. To help reverse the epidemic, high priority should be given to poverty-reduction strategies, girls' education, women's economic opportunities and other basic reforms.[78]

The Secretary-General's Report was accompanied by an assessment prepared by UNAIDS on scaling up HIV prevention, treatment, care and support.[79] This assessment report again emphasises the particular vulnerability of young people and women, and ascribes this to their lack of economic and social power and autonomy in their sexual lives.[80] It notes that they are often denied the tools and information required to avoid infection and cope with AIDS.

The report further points out that AIDS is a social and cultural issue. Confronting the epidemic requires discussion and action on issues that some societies find uncomfortable, such as gender

equality, sexual and reproductive health, sex work, homosexuality and injecting drug use.[81] At the same time, AIDS is also a health, development and human security issue.[82]

The assessment contains an analysis of the major obstacles to scaling up of HIV prevention, treatment, care and support, and identifies the major requirements to overcome these obstacles. It also sets out specific recommendations to help meet these requirements with suggested deadlines for their implementation. The six major obstacles are setting and supporting national priorities; predictable and sustainable funding; strengthening human resources and systems; affordable commodities; stigma, discrimination, gender and human rights; and targets and accountability.

In terms of *discrimination, gender and human rights*, the main recommendation is for governments to protect and promote the AIDS-related human rights of people living with HIV, women and children, and people in vulnerable groups, and ensure that they are centrally involved in all aspects of the response. It is therefore recommended that national governments and international donors should increase funding for programmes to address gender inequalities that fuel the epidemic among women and girls, reform and enforce legislation, where needed, to protect women and girls from harmful traditional practices and from sexual violence in and outside marriage and ensure equality in domestic relations, including in respect of property and inheritance rights of women and girls.[83]

The assessment report notes that the country and regional consultations consistently reported that legal, social and cultural barriers are undermining access to interventions for those most at risk of HIV infection and most affected by AIDS.[84] Violence against women and other vulnerable groups and other HIV-related human rights abuses are still widespread. However, HIV-related human rights are not high enough among the priorities of national governments,

donors or human rights organisations.

The report points out that the low status of women in many societies fuels the transmission of HIV and worsens its impact. The Africa consultation emphasised that scaling up towards universal access would not be possible on that continent without a central focus on the needs of women and girls.[85] Many consultations stressed that the development and enforcement of supportive laws and protection of human rights – including the rights of women and children – must remain priorities.[86] Greater resources and political commitments must be mobilized to address problems of stigma, discrimination, gender and human rights.[87]

8.3 High-Level Meeting and Political Declaration

The consultation and review process culminated in a high level meeting attended by Heads of State and Government in June 2006. On 2 June 2006, the General Assembly adopted a *Political Declaration on HIV/ AIDS*,[88] which marked the conclusion of the review process. The participants noted, with alarm, that the world is facing an unprecedented human catastrophe,[89] and recognised that HIV/ AIDS constitutes a global emergency that poses one of the most formidable challenges to the development, progress and stability of their respective societies and the world at large and requires a comprehensive global response.[90] They expressed their concern about the overall expansion and feminisation of the epidemic, and recognise that gender inequalities and all forms of violence against women and girls increase their vulnerability to HIV/ AIDS.[91]

The *Political Declaration* reiterates with profound concern that although the pandemic affects every region, Africa and in particular sub-Saharan Africa, remains the worst affected region.[92]

Therefore urgent and exceptional action is required at all levels to curb the devastating effects

of the pandemic. Participants accordingly recognise the renewed commitments by African governments and regional institutions to scale up their own HIV/ AIDS responses.

Participants pledge to –

ຂ eliminate gender inequalities, gender-based abuse and violence;

ຂ increase the capacity of women and adolescent girls to protect themselves from the risk of HIV infection, principally through the provision of health care and services, including (amongst others) sexual and reproductive health, and the provision of full access to comprehensive information and education;

ຂ ensure that women can exercise their right to have control over, and decide freely and responsibly on, matters related to their sexuality in order to increase their ability to protect themselves from HIV infection, including their sexual and reproductive health, free of coercion, discrimination and violence; and

ຂ take all necessary measures to create an enabling environment for the empowerment of women and strengthen their economic independence.[93]

They further commit themselves to strengthening legal, policy, administrative and other measures for the promotion and protection of women's full enjoyment of all human rights and the reduction of their vulnerability to HIV/ AIDS through the elimination of all forms of discrimination, as well as all types of sexual exploitation of women, girls and boys, and all forms of violence against women and girls, including harmful traditional and customary practices, abuse, rape and other forms of sexual violence, battering and trafficking in women and girls.[94]

The *Political Declaration* ends with a decision to undertake comprehensive reviews in 2008 and 2011 of the progress achieved in realizing the 2001 Declaration of Commitment as well as the present Declaration.[95]

The *Political Declaration* was met with mixed reaction. In a carefully worded press release, UNAIDS noted that while many were encouraged by the strong new language in the Declaration, "some UNAIDS partners were disappointed that UN Member States did not go as far as they could to agree on clear new language regarding global targets and vulnerable groups, including injecting drug users, men who have sex with men, and sex workers".[96] Civil society groups were specifically critical of the fact that UN Member States were not willing to commit themselves to "hard targets" on funding, prevention, care and treatment.[97] Particular indignation was directed at African government delegations for reneging on the promises in the 2006 Abuja Common Position agreed to by African Heads of State.

9. Draft SADC Protocol on Gender and Development

9.1 Background
On 8 September 1997, a *Declaration on Gender and Development* was adopted by the SADC member states in Malawi. Building on the *SADC Treaty*, the *Convention on the Elimination of All Forms of Discrimination of Violence against Women*[98] and the *Beijing Platform of Action*,[99] the Declaration sets out a number of actions to be taken by member states. These include taking urgent measures to prevent and deal with the increasing levels of violence against women.[100]

Following the adoption of this Gender Declaration, SADC member states made further detailed commitments regarding measures to address violence against women and children when the Heads of State and Government agreed on an Addendum to the Declaration in September 1998. The *Addendum on the Prevention and Eradication of Violence Against Women and Children* recognizes that violence against women reflects the unequal relations of power between women and

men, resulting in the domination and discrimination of women by men.[101] It contains a broad definition of violence against women, which includes economic deprivation, marital rape and traditional practices harmful to women.[102]

Signatories resolved that a number of measures should be adopted, including the allocation of resources necessary to ensure the implementation and sustainability of the programmes set out in the document.[103] They further decided that regional policies, programmes and mechanisms to enhance the security and empowerment of women and children be adopted and their implementation monitored,[104] and that urgent consideration be given to the adoption of legally binding SADC instruments on preventing violence against women and children.[105]

In 2005, the process of transforming the Declaration and its Addendum into a binding document formally commenced. A campaign was initiated to elevate the Declaration on Gender and Development to a document with legally binding status.[106] This initiative was coordinated by the SADC Secretariat in collaboration with civil society organizations.[107] The objective was to give global and continental commitments meaning at sub-regional level. The campaign arose from an audit of the Declaration on Gender and Development in 2005 (the tenth anniversary of the Fourth World Conference on Women in Beijing and the target set by SADC for the achievement of 30% women in decision-making). This audit showed that while significant progress had been made since the signing of the Declaration in 1997, several gaps remained. For example, laws, systems and services for addressing gender-based violence were inconsistent and inadequate. Furthermore, the disproportionate impact of the AIDS pandemic on women, and especially young women, was becoming increasingly apparent.

In 2006, the SADC Gender Unit formed a task team of government and civil society organizations to draft the Protocol, and in November 2006 the

Gender Ministers met in Lesotho, added their comments and made it available for comment.[108] They also agreed to lead national consultations in their home countries ahead of a consultative conference, which took place in Gaberone in April 2007. The resulting draft was endorsed by the Gender Ministers in July, and subsequently submitted to the Summit of Heads of Government in August 2007, with the assumption that it would be adopted.

9.2 Provisions of the draft Protocol

Article 6(2) provides that State Parties shall enact and enforce legislative and other measures to ensure equal access to justice and protection before the law, eliminate practices that are detrimental to the achievement of the rights of women by prohibiting them and attaching deterrent sanctions thereto, and eliminate gender-based violence.[109]

The draft Protocol contains extensive provisions on gender-based violence, and in this respect it can be said to be the most far-ranging document of its kind. Part Six of the draft Protocol is devoted to gender-based violence, and consists of six articles that deal with various aspects of the obligations resting on State Parties to address gender violence.

Article 22 deals with legal aspects, and firstly enjoins State Parties, by 2015, to enact and enforce legislation prohibiting all forms of gender-based violence, and to ensure that perpetrators of gender-based violence are tried by a court of competent jurisdiction. Secondly, State Parties must ensure that laws on gender-based violence provide for the comprehensive testing, treatment and care of survivors of sexual offences, which must include the following –

- Emergency contraception;
- The right to terminate a pregnancy where it is the result of a sexual offence;
- Ready access to PEP at all health facilities to reduce the risk of contracting HIV;

♀ Preventing the onset of sexually transmitting infections.

State Parties must further, by 2010, review and reform their criminal laws and procedures applicable to cases of sexual offences and gender-based violence to eliminate gender bias and ensure justice and fairness are accorded to victims and survivors of gender-based violence in a manner that ensures dignity and respect.

On a procedural level, State Parties must ensure that in all cases of gender-based violence, cases are handled by police who are gender sensitive, cases are heard by judges who are gender sensitive, cases are heard in camera, and that complainants are not subjected to abusive and degrading language. Where children are involved, the assistance of a social worker must be provided, and free medical services must be provided. State Parties must furthermore establish Special Courts to address cases of gender-based violence, and establish special counseling services, legal and police units to provide dedicated and sensitive services to victims of gender-based violence.[110]

In addition, State Parties must put in place measures to eradicate gender-based violence in educational institutions, and provide resources and mechanisms for the social and psychological rehabilitation of perpetrators of gender-based violence. Article 22 further contains detailed provisions regarding human trafficking.

Article 23 addresses traditional norms, including social, economic, cultural and political practices and religious beliefs that legitimise and exacerbate the persistence and tolerance of gender-based violence. The state's responsibilities in this respect include creating public awareness and introduction and support of gender sensitisation programmes aimed at changing behaviour.

Part 6 of the draft Protocol also sets out in some detail that State Parties should provide services to victims of gender-based violence, including police, prosecutorial, health, social

welfare and legal services.[111] It further provides guidance on the training of service providers, including police, judiciary, health and social workers, community sensitisation programmes and the training of service providers to enable them to offer services to people "with special needs".[112] Finally, the draft Protocol calls for the adoption of integrated approaches, including "institutional cross sector structures", in order to end gender-based violence.[113]

Compared with the section dealing on gender-based violence, Part 7, which deals with health, is noticeably brief. Article 28(1) requires State Parties to adopt and implement legislative frameworks, policies, programmes and services to enhance gender sensitive, appropriate and affordable quality health care particularly in maternal health, sexual and reproductive health, in line with the SADC Protocol on Health. State Parties must ensure the provision of quality, gender sensitive health care and services in sanitation, mental health, communicable diseases and nutrition "amongst other things".

Article 29 deals with HIV and AIDS, and provides that State Parties must take every step necessary to adopt and implement gender sensitive policies and programmes in prevention, treatment, care and support in accordance with the *Maseru Declaration on HIV and AIDS*.

The implementation of the Protocol is dealt with in Article 37 under the heading of "Monitoring and Evaluation". State Parties are required, by 2015, to develop, monitor and evaluate systems and plans setting out targets, indicators and time frames based on the Protocol. Each State Party must collect and analyse baseline data against which progress in achieving these targets will be monitored. The most important monitoring instrument will be annual reports, to be submitted to the Secretariat by State Parties, indicating their progress achieved in implementation of the measures in the Protocol.

In reporting on the implementation of the

Protocol, State Parties will make use of a reporting template (to be disseminated by the SADC Secretariat). Sanctions for non-compliance will be imposed on State Parties in accordance with Article 33(2) of the SADC Treaty. Any dispute arising from the application, interpretation or implementation of the Protocol, which cannot be settled amicably, must be referred to the SADC Tribunal, in accordance with Article 16 of the Treaty.[114]

The Protocol does not make provision for State Parties to register reservations to any of its provisions, although a State Party may propose an amendment to the Protocol, which will be adopted by a decision of three-quarters of State Parties.[115]

9.3 Current status of the draft Protocol

A final draft version of the Protocol was discussed at the Summit of Heads of State and Government in Lusaka in August 2007, and a number of fairly incisive changes were made. For example, article 29, which deals with HIV and AIDS, previously made extensive provision for various aspects of the pandemic of specific concern to women.[116] This version was replaced with the current anodyne provision as outlined above.

Although it was widely expected that the document would be finalized and signed on this occasion, representatives decided to defer signature until 2008 in order to allow Member States to hold further national consultations.[117] Organisations involved in the process leading up to the presentation of the final draft to the Summit have expressed their disappointment at this delay.[118]

10. Summary

As the above analysis shows, the notions of gender equality and the gendered aspects of the pandemic feature in the body of documents setting out the

commitments undertaken by SADC countries to address HIV/AIDS since 2000 in increasingly stronger terms. In certain instances, such as the *UN Declaration of Commitment* of 2001, an express link is made between women's and girls' increased vulnerability to HIV infection and gender-based violence. This connection is again emphasized in the 2006 UNAIDS assessment report, submitted to the UN General Assembly in preparation for the 2006 Follow-up session, on scaling up HIV prevention, treatment, care and support. The report recommended that national governments and international donors should increase funding for programmes to address gender inequalities that fuel the epidemic among women and girls, to reform and endorse legislation, where needed, to (inter alia) protect women and girls from harmful traditional practices and from sexual violence inside and outside marriage. Significantly, the *Political Declaration*, which came out of the High-Level Meeting of Heads of State and Government in June 2006, saw participants unequivocally pledging to eliminate gender inequality, gender-based abuse and violence.

Although the SADC Protocol on Gender and Development is currently only in draft form, it is a document that holds great promise, given its potential to become legally binding on a member state when it ratifies the Protocol.[119] One therefore hopes that the provisions on HIV/AIDS will be strengthened during the final round of country consultations in 2008, and that the document will be adopted and signed by the Heads of State and Government at the Summit in August 2008.

1 Notable omissions are the New Partnership for African Development [NEPAD], the AU Solemn Declaration on Gender Equality in Africa, the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women, and the AU HIV/AIDS Strategic Plan 2005-2007.

2 UN Millennium Declaration A/Res/55/2 (dated 18 September 2000) at Par 19.

3 See World Bank *Millennium Development Goals: Confronting the Challenges of Gender Equality and Fragile States* (2007) at 105-148 for a detailed discussion of progress in achieving MDG3.

4 UNAIDS *Monitoring the Declaration of Commitment on HIV/AIDS: Guidelines on Construction of Core Indicators* (2005) at 9.

5 Par 22.

6 Par 26.

7 Par 26.

8 Par 24.

9 Par 31.

10 Par 7 of the Preamble.

11 See Par 5-9 of the Declaration.

12 UNGA Special Session Resolution S-26/2 *Annex - Declaration of Commitment on HIV/AIDS "Global Crisis - Global Action"* UN Doc A/Res/S-26/2 dated 2 August 2001.

13 Par 2.

14 Par 4.

15 Par 14.

16 Par 8.

17 Par 9.

18 Because gender is not specifically mentioned in each of the ten focus areas, this discussion is of necessity somewhat fragmented.

19 Par 47.

20 Par 47.

21 Par 53.

22 Par 54.

23 Par 59.

24 Par 60.

25 Par 61.

26 Par 62.

27 Par 68.

28 Preamble.

29 Preamble.

30 Preamble.

31 Par 1(c).

32 Par 1(d).

33 Par 3(a).

34 Par 4(a).

35 Par 5(c).

36 WHO/ AFRO Press Release: "Meeting adopted Brazzaville Commitment on Scaling Up Towards Universal Access to HIV and AIDS Prevention, Treatment, Care and Support in Africa" (8 March 2006).

37 WHO/ AFRO Press Release (above). See discussion of 2006 Abuja Summit below.

38 Par 1.

39 Par 2.

40 Par 3.

41 Par (b).

42 Par 5(p).

43 Par 5(q).

44 Par 5(r).

45 Par 5(v).

46 African Union *Aide Memoire: Special Summit of African Union on HIV/AIDS, Tuberculosis and Malaria (ATM), Abuja, Nigeria 2–4 May, 2006* at Par 5.

47 Sp/Assembly/ATM/2(I)Rev.3 (2006).

48 Par 3.

49 Botswana – see Fakier (ed) *HIV/AIDS and Human Security* (2005) at 33.

50 Par 7.

51 See 3.4 above. The participants agreed to extend the recommendations and action points enshrined in the Brazzaville Commitment to tuberculosis and malaria and other prevailing diseases – Par 12.

52 Par 8.

53 Par 10.

54 Par 10.

55 Par 14.

56 See Par 3-7 of the 2006 Abuja Call for Action.

57 In 2002, UNAIDS develop a series of core indicators to measure progress in implementing the *Declaration of Commitment*. The core indicators were grouped into four broad categories: (i) national commitment and action; (ii) national knowledge and behaviour; (iii) national impact; and (iv) global commitment and action. In 2003, 103 member states submitted national reports to UNAIDS based on the original core indicators. From a global perspective, there were serious limitations to the data submitted. For example, less than 20% of the national-level data submitted was disaggregated by gender, age, location etc, which complicated the ability to draw valid conclusions from the data. There was also an uneven level of reporting between regions, with the highest proportion of responding countries per region coming from sub-Saharan Africa and the lowest level of reporting from countries in North Africa and the Middle East. In order to improve the quality of data submitted for the 2006 *Global Progress Report*, refinements were made to the national indicators and their accompanying guidelines - UNAIDS *Monitoring the Declaration of Commitment on HIV/AIDS: Guidelines on Construction of Core Indicators* (2005) 7-8. These indicators were supplemented in 2007, with a question introduced under the "Prevention" indicator asking whether national Information and Education Campaigns included messages promoting the fight against violence against women – see UNAIDS *Guidelines on Construction of Core Indicators: 2008 Reporting* (2007) at 112.

58 *Declaration of Commitment on HIV/AIDS: Five Years Later – Report of the Secretary-General* UN Doc A/60/736 dated 24 March 2006 at Par 9.

59 They are: Angola, Botswana, DRC, Madagascar, Malawi, Mozambique, Namibia, South Africa, Swaziland, Tanzania, Zambia, Zimbabwe.

60 This review does not include the reports from Angola and Madagascar, which are in Portuguese and French respectively. We unfortunately had to limit ourselves to reports written in English for present purposes.

61 See Government of Mozambique *UNGASS Declaration of Commitment on HIV/AIDS: Progress Report Reporting Period 2003 2003* (January 2006) 35-36; Office of the President and Cabinet *Malawi HIV and AIDS Monitoring and Evaluation Report 2005* (December 2005) 50; Zambia National HIV/AIDS/STI/ TB Council *Follow-up to the Declaration of Commitment on HIV/AIDS (UNGASS)* (January 2005) at 2.

62 See discussion above.

63 Department of Health *Republic of South Africa: Progress Report on Declaration of Commitment on HIV and AIDS* (March 2006) at 4.

64 Ibid.

65 Ibid.

66 Tanzanian Commission for AIDS *Follow-up to the Declaration of Commitment on HIV/ AIDS Reporting Period January 2003 – December 2005* at 13.

67 Ibid.

68 Idem (above) at 17.

69 *Report of the Secretary-General* (above).

70 Par 14.

71 Par 14.

72 The report contains a general introductory section, and then sets out progress under each of the ten areas contained in the Declaration of Commitment. Because of the fact that "women" or "gender" are not specifically addressed under each area, we have not followed this division here.

73 Par 10(c).

74 Par 23.

75 Par 56.

76 Par 10(h).

77 Par 59.

78 Par 59.

79 *Towards Universal Access: Assessment by the Joint United Nations Programme on HIV/AIDS on Scaling Up HIV Prevention, Treatment, Care and Support* UN Doc A/60/737 dated 24 March 2006.

80 Par 6.

81 Par 8.

82 Par 9-11.

83 Recommendation 5.2.

84 Par 44.

85 Par 46.

86 Par 47.

87 Par 49.

88 Resolution 60/262 *Political Declaration on HIV/ AIDS* UN Doc A/Res/ 60/262 dated 15 June 2006.

89 Par 2.

90 Par 3.

91 Par 7.

92 Par 10.

93 Par 30.

94 Par 31.

95 Par 53.

96 UNAIDS Statement: "2006 High Level Meeting on AIDS" (20 June 06).

97 Press Release: "International civil society denounce UN meeting on AIDS as a failure" (2 June 2006).

98 Adopted 18 December 1979, G.A. Res 34/180, UN GAOR, 34th Session, Supp No 46, U.N. Doc A/34/36 (1980).

99 Beijing Declaration and Platform of Action UN GAOR, UN Doc A/Conf. 177/20 (1995).

100 Par H.

101 *Addendum* at Par 3.

102 Par 5(a)-(c).

103 Par 24.

104 Par 25.

105 Par 26.

106 Gender Links *The SADC and Gender 2005 Campaign: Fact Sheet 1* (2005).

107 C Warioba & AG Luhanga "SADC initiatives aimed at combating gender-based violence" in E Delport (ed) *Gender-Based Violence in Africa* (2007) at 41.

108 Gender Links *SADC Gender and Development Protocol National Consultation* (2007).

109 Articles 6(2)(a), (c) and (e) respectively. Our discussion here refers to the version accepted by the Summit of Heads of State and Government in August 2007.

110 Art 22(8) and (9).

111 Art 25.

112 Art 26.

113 Art 27.

114 Art 38(2).

115 Articles 40(1) and (3).

116 See article 10 of the draft as submitted to the Summit (reference number SADC/M/2007/GAD/2) – copy on file with authors.

117 B Lopi "Gender Protocol referred to Member States for more consultations" *The Gender and Development Exchange* (July-September 2007). Issue 43.

118 Gender Links Press Release: "Southern African NGOs condemn backtracking on Gender Protocol" (13 November 2007).

119 The Protocol, once in force, will be the only legally binding one among the documents discussed in this Section.

SECTION 4: SADC INITIATIVES

1. Introduction

This section provides a brief overview of the SADC strategies initiated since 2000 to address HIV/AIDS on a regional level. We first look at the *SADC Strategic Framework on HIV and AIDS*, and then examine the *SADC HIV and AIDS Business Plan*. Finally, the section concludes with an overview of the *SADC Strategic Action Plan* for Universal Access to HIV Prevention (2008-2010).

2. SADC Strategic Framework on HIV and AIDS

2.1 Background: The Strategic Framework 2000-2004

As an initial step, the *SADC Strategic Framework (2000-2004)* guided the implementation of the regional response to HIV/AIDS.[1] This Framework promoted a multi-sectoral response driven by the individual sectoral coordinating units located in different SADC member states.[2] The Health Sector Coordinating Unit was given the mandate to provide overall coordination of the regional response.

Drawing on its advantage of being a regional institution, SADC facilitated the sharing of experiences and best practices amongst member states in the areas of research and policy development, capacity building, programme delivery, development of standards and resource mobilisation.[3] Examples of these activities include:[4]

Research and policy development:
- Development of the SADC Code on HIV/AIDS and Employment, a policy guideline that facilitates best practices at the workplace in the context of HIV/AIDS;
- The SADC Education Policy Support Initiative supported studies on HIV/AIDS Education Policy.

Facilitation of sharing of best practices
Best practices were shared amongst member states in the areas of nutrition, VCT, PMTCT, and mainstreaming gender and human rights and HIV/AIDS programmes.

Programme delivery
The SADC Transport Sector supported initiatives aimed at HIV prevention, including projects focusing on long-distance truck drivers and commercial sex workers.

Capacity building and development of standards
- Capacity building was done in the Education Sector with the focus on planning for the impact of HIV/AIDS on the availability of teachers;
- Standards in VCT were developed to guide member states in the implementation of VCT programmes.

Resource mobilisation
The Health Sector mobilized more than US$20 million (from external donors) to support the implementation of HIV/AIDS initiatives in Southern Africa until early 2006.

Challenges encountered in the 2000-2004 regional response

The regional response in terms of the *2000-2004 Strategic Framework* faced similar challenges to those encountered on national level by member states.[5] These included the multi-sectoral nature of the response, inadequate monitoring of regional initiatives such as the Code of Conduct on HIV/AIDS and Employment to ensure implementation on national level, and lack of resources (financial and personnel) required for an effective response. The implementation of the Strategic Framework was also made more difficult by structural factors such as the geographic spread of the sector coordinating units.[6]

In 2003, the SADC Secretariat was restructured (as explained above).[7] These new circumstances made it important to realign the region's response to HIV/AIDS, and provided an opportunity to revise the *2000-2004 Strategic Framework* to mainstream HIV/AIDS within all policies and programmes being undertaken by SADC, reflecting the challenges and priorities of the region in responding to the epidemic.[8] The resulting new *Strategic Framework (2003-2007)* is discussed below.

2.2 SADC Strategic Framework on HIV and AIDS 2003-2007

The vision of the *2003-2007 Strategic Framework* is to significantly reduce levels of HIV/AIDS within SADC.[9] The Framework has as its overarching goal to decrease the numbers of people living with and affected by HIV/AIDS in the SADC region, so as to ensure that HIV/AIDS is no longer a threat to the public health and to the sustained socio-economic development of member states.[10]

The main objectives of the Strategic Framework are the following:

- To reduce the incidence of new infections among the most vulnerable populations within SADC.
- To mitigate the socio-economic impact of HIV/AIDS.
- To review, develop and harmonise policies and legislation relating to HIV prevention, care and support, and treatment within SADC.
- To mobilize and coordinate resources for a multi-sectoral response to HIV/AIDS in the SADC region.
- To monitor the implementation of the SADC Framework and regional, continental and global commitments ensuring that gender is fully mainstreamed.

The Framework identifies the following main areas of strategic focus:[11]

1) *Policy Development and Harmonisation*
   SADC will promote policy development, harmonization and the establishment of Protocols in a number of areas, including –
   - care and treatment (including the use of ARV's);
   - nutrition, nutritional therapies and traditional herbs;
   - human resource needs in all sectors in the context of HIV/AIDS;
   - regional issues such as HIV/AIDS and migrant population/ mobile labour, refugees and displaced populations;
   - bulk procurement of drugs and medical supplies for HIV/AIDS; and
   - policy guidelines on increasing access to care and treatment to the most vulnerable social groups.

2) *Mainstreaming HIV/AIDS in SADC*
   The objective of the Strategic Framework is to mainstream HIV/AIDS into all the policies,

programmes and activities being developed and implemented by Directors, Units and all other SADC entities. The areas for mainstreaming include policy level, progamme and project level and activity level.

3) Capacity Building
The strategic Framework aims to strengthen the capacity of SADC to mainstream HIV/AIDS at all levels.[12]

4) Facilitating a Technical Response
SADC will establish mechanisms to facilitate technical discussions, develop regional guidelines and facilitate the sharing of best practices in a number of areas, including –

- mainstreaming of HIV/AIDS;
- PMTCT;
- research and surveillance, taking into account anthropological and epidemiological factors; and
- mitigation of HIV/AIDS.

5) Facilitating Resource Networks
The Strategic Framework acknowledges that resources of people and organisations that have the necessary technical skills to assist with the response to the epidemic exist within member states. The SADC Secretariat will undertake an assessment of national and regional resources, seek to mobilize these resources into networks to facilitate information exchange and collaboration, share scientific information, map available resources, share best practices and focus on activities that support common regional needs. Some of the expected outcomes and networks include –

- collaboration and sharing of research facilities and results;
- regional training and research;
- collaboration in inter-country programmes such as cross-border initiatives and migrant labour; and
- development of a regional data bank.

6) Facilitating the Monitoring of Regional and Global Commitments
SADC will facilitate the monitoring of the performance of member states in meeting their regional, continental and global commitments in the following areas:

- Assessment of individual country performances with respect to the *Maseru Declaration*, *Abuja Declaration*, MDG and UNGASS targets for HIV/AIDS and related indicators and the publication of regular reviews for SADC.
- Facilitation of processes to assist member states that are not achieving the various targets, by strengthening national capacities in relevant areas.

3. SADC HIV and AIDS Business Plan

In 2003, the SADC HIV and AIDS Unit developed a five-year *Business Plan* aimed at providing direction on interventions, activities and performance indicators required to address the epidemic. Annual plans form the basis for the implementation of the *Business Plan*.[13]

The *Business Plan* was developed within the context of three key SADC policy documents, ie the *SADC Regional Indicative Development Plan*, *SADC Strategic Framework on HIV and AIDS (2003-2007)* and the *Maseru Declaration (2003)*.[14] It focuses on the following five main areas:[15]

- Policy development and harmonisation;
- Capacity building and mainstreaming of HIV/AIDS into all SADC policies and plans;
- Facilitating a technical response, resource networks, collaboration and coordination;
- Intensifying resource mobilization for the regional multi-sectoral response; and
- Monitoring and evaluating the multi-sectoral response to the epidemic.

The Plan aims to provide a detailed, time-bound 'road map', identifying intervention areas, key

activities and performance indicators, as well as the role of different stakeholders.[16] In addition, a set of Project Concept Notes has been developed, based on the *Business Plan*, for the purpose of financing the activities.[17]

The implementation of the *Business Plan* is driven by the HIV and AIDS Unit. Given the multi-dimensional, multilevel and multi-sectoral nature of the epidemic, the HIV and AIDS Unit is required to work closely with the SADC Secretariat Directorates and the other SADC Units, as well as member states.[18]

By 2007, the following milestones had been reached under the five main focus areas.[19] (The list below provides examples only, and is not exhaustive).

1) Policy development and harmonisation
ℵ Principles have been developed to guide negotiations with the pharmaceutical industry on medicines, including ARV medicines for the treatment of HIV/AIDS;
ℵ Guidelines have been developed for media reporting on HIV.

2) Capacity building and mainstreaming of HIV/ AIDS into all SADC policies and plans[20]
A framework for mainstreaming HIV/AIDS has been developed, which provides a common understanding among member states and the SADC Secretariat of the definition, concepts, principles, tools and indicators of HIV/AIDS mainstreaming.

3) Facilitating a technical response, resource networks, collaboration and coordination[21]
ℵ A forum for National AIDS Authorities has been established. This national event enables leadership on national AIDS programmes to exchange views on issues of regional interest and also to share best practices on HIV/AIDS.
ℵ Sharing of best practices:
  • *Expert Think Tank Meeting* (May 2006) – identified the drivers of the epidemic and

summarised evidence of interventions and proposed national and regional actions.
  • *SADC Regional Consultation on Social Change Communications* (October 2006) – agreed on regional framework for social change communication to strengthen regional social and behavioural programmes aligned to the drivers.

4) Intensify resource mobilization for the regional multi-sectoral response[22]
ℵ Development of the SADC Trust Fund on HIV/ AIDS;
ℵ The harmonisation of funding from like-minded donors.

5) Monitoring and Evaluation
The Secretariat has developed a Regional Monitoring and Evaluation Framework on HIV/ AIDS. This Framework allows for monitoring progress in prevention.

When the Business Plan was published in 2004, the total budget for its implementation was calculated at US$22,770,900.[23] SADC reported in 2006 that although some funding had been mobilised for the implementation of the Plan, there was still a significant shortfall towards the total amount.[24]

4. Access to HIV Prevention: Strategic Action Plan

In order to improve the effectiveness[25] of HIV prevention efforts, thereby ensuring that HIV incidence declines significantly within each member state and the region as a whole, a regional strategy document entitled *"Towards Universal Access to HIV Prevention: SADC Strategic Action Plan 2008-2010"* has been developed. The *Strategic Action Plan* builds upon and is complementary to the *SADC HIV and AIDS Strategic Framework (2003 – 2007)*.[26]

4.1 Background: Overview of prevention efforts in Southern Africa

The strategy document observes that while national HIV/AIDS responses differ across SADC member states, these responses have all grown in scale and sophistication over the last decade, and lists as an example the fact that country-level responses now complement national planning for poverty alleviation and national development.[27] The prevention of new infections remains seriously challenged by a host of behavioural and structural factors, and the modest achievements shown by SADC member states, while encouraging, are not sufficient to stem the tide of the epidemic.

The SADC regional response has demonstrated the potential benefits of collective action against HIV.[28] However, a number of challenges have been encountered, which continue to influence the quality of the regional response. These include:

- balancing regional interests and country priorities: developing policies that allow scope for member states to act in their own interest yet do so in line with regional agreements and established standards;
- weak monitoring, evaluation and reporting: negotiating common indicators for monitoring that are relevant and feasible for all fourteen member states and motivating routine analysis and reporting that is meaningful to prevention planning; and
- mobilising the resources needed as well as supporting more efficient utilisation of resources already mobilised for interventions aligned to the regional strategy.

Prevention efforts may require the introduction of new programmes as well as the expansion of existing ones.[29] As member states balanced competing priorities, not all aspects were addressed, and important gaps remain. These include (amongst others):

- health infrastructure to support the expansion in the scope and reach of prevention services;
- services for survivors of sexual violence, including post-exposure prophylaxis (PEP);
- more consistent integration of gender equity promotion within HIV response efforts; and
- supports for managing prevention in people living with HIV/AIDS and discordant couples.

Against this background, the *SADC Strategic Action Plan* has been developed with the vision of coordinated regional action to end new infections.[30] Its goal is to support member states in their efforts to significantly reduce the incidence of new HIV infections so that HIV Prevalence declines.

The objectives of the *Strategic Action Plan* are as follows:

- to develop and harmonise HIV prevention policies and practices across member states;
- to build capacity of member states to plan, design, deliver, monitor and evaluate HIV prevention programmes for greater effectiveness;
- to facilitate networking and sharing of programme experiences, successes and best practice in HIV prevention from member states and SADC initiatives; and
- to mobilise and ensure effective utilisation of resources for HIV prevention.

The *Strategy Action Plan* is based on a number of guiding principles,[31] which include (amongst others) promotion, protection and respect for human rights, including women's rights, and promotion of gender equity - "the integration of strategies for empowering women and engendering equality in access, participation and control over resources for HIV prevention".

4.2 Strategic Areas of Regional Focus

1) Harmonising Policy and Practice

Current levels of population movement throughout the region necessitate a greater level of harmonisation of policy and practice, specifically in the context of HIV.[32] Migrant workers and their families, refugees and displaced populations face different

policies and health care practices as they move across national borders. These sometimes inhibit access to diagnostic and treatment services or disrupt care in ways that discourage prevention. An important area of focus therefore is the creation of unified policy and standardised care. Specifically, this component of the strategy seeks to, for example, create and support implementation unified guidelines relating to sexual and reproductive health (including male circumcision) across the region.

2) Building Capacity for More Effective Prevention
National AIDS authorities are not always able to support new priorities for HIV response or integrate new developments for strengthening HIV prevention.[33] They are sometimes limited in important technical areas of functioning through the lack of requisite skills, systems or both. The *SADC Strategic Action Plan* therefore focuses on building capacity for more effective prevention through (amongst others) strengthening the capacity of National AIDS Authorities to gather strategic data to inform planning; institute processes that support evidence-based planning across sectors; monitor and assess effectiveness of prevention efforts and maintain high quality management information systems to inform national and regional decisions on prevention.

3) Strengthening Networks and Sharing of Lessons Learned
The *SADC Strategic Action Plan* builds on the experiences, expertise and influence of a range of networks responding to the epidemic within and across SADC.[34] Networks have the potential to play a critical role in determining how HIV prevention is addressed and the degree to which prevention goals are achieved within SADC. The *Action Plan* therefore focuses on:

⚥ strengthening the capacity of networks to share community needs and experiences; to analyse

challenges to HIV prevention and to inform strategies on ways forward;

⚥ facilitating the sharing of experiences for improving key prevention initiatives like communications for social and behavioural change, prevention among youth, male circumcision, female empowerment;

⚥ supporting member states in their documentation, sharing and adoption of best practices, particularly in areas posing special challenges to prevention; and

⚥ convening experts and technical workgroups to shape response to gaps, persistent challenges and emerging issues in HIV prevention.

4) Mobilising Resources for More Effective Prevention
Increased allocation and improved utilisation of resources are needed to address all priority areas in the *SADC Strategic Action Plan* for HIV Prevention.[35] The SADC Secretariat, through its HIV and AIDS Unit, will continue to nurture existing relationships with development partners, seek out new partnerships for increased funding and urge member states towards meeting their commitments to the health budget.

4.3 Implementation Mechanisms
The SADC Secretariat, through the HIV and AIDS Unit will drive the implementation of the *Strategic Action Plan* in collaboration with the HIV response machinery in member states (National AIDS authorities), regional partners and international partners.[36]

5. Summary
As noted by Viljoen and Precious, SADC has been the most active of all the African regional economic communities in responding to the AIDS pandemic.[37] (The authors add that this is hardly surprising, given that globally this subregion has been struck the hardest by the pandemic.) Looking at the *SADC Strategic Framework on HIV and AIDS*, as comple-

mented by the 5-year *HIV and AIDS Business Plan*, as well as the draft *Strategic Action Plan* on prevention, one notes that a fairly comprehensive (and ambitious) framework is in place and is systematically being operationalised, subject to a number of recognized practical constraints and challenges. Prominent among these constraints is a lack of financial, human and institutional resources on both national and subregional level.[38]

The *SADC HIV and AIDS Business Plan* has been developed within the structure of the *Strategic Framework on HIV and AIDS*, which lists among one of its objectives "ensuring that gender is fully mainstreamed".[39] Another component of the underlying structure is the *Regional Indicative Strategic Development Plan*, which lists both HIV/AIDS and gender equality (including gender-based violence) as cross-cutting priority intervention areas.[40] Against this background, one would perhaps have expected more express recognition of the linkages between HIV/AIDS and gender-based violence. However, the *Business Plan* is sufficiently broad and flexible to permit the inclusion of such recognition, and we make certain recommendations in this regard below.[41]

1   SADC *SADC HIV and AIDS Strategic Framework and Programme of Action 2003-2007* (July 2003) [hereinafter referred to as '*Strategic Framework*'] at 8.

2   SADC *Strategic Framework* at 8-9; see also CM Warioba & AG Luhanga "SADC initiatives aimed at combating gender-based violence" in E Delport (ed) *Gender-Based Violence in Africa* (2007) at 32 for a brief explanation of the role of the national sector coordinating units.

3   SADC *Strategic Framework* at 9.

4   SADC *Strategic Framework* at 9-10.

5   SADC *Strategic Framework* at 10.

6   SADC *Strategic Framework* at 10.

7   See page 21 above.

8   SADC *Strategic Framework* at 3.

9   SADC *Strategic Framework* at 11.

10 SADC *Strategic Framework* at 11.

11 SADC *Strategic Framework* at 12.

12 SADC *Strategic Framework* at 13.

13 SADC *Subtheme on HIV and AIDS* (2006) at 3.

14 SADC *Subtheme on HIV and AIDS* (2006) at 5. For other documents informing the Business Plan, see 3.

15 SADC *Subtheme on HIV and AIDS* (2006) at 5.

16 SADC *SADC HIV and AIDS Business Plan* (2004) at 5.

17 Prospective partners who are interesting in supporting different intervention areas can therefore select from a 'menu' of activities and provide the necessary financial and technical input – SADC *SADC HIV and AIDS Business Plan* (2004) at 5.

18 SADC *SADC HIV and AIDS Business Plan* (2004) at 12.

19 SADC *Towards Universal Access to HIV Prevention: SADC Strategic Action Plan 2008-2010* (August 2007) ['hereinafter referred to as 'Towards Universal Access'] at 14.

20 SADC *Towards Universal Access* at 15.

21 SADC *Towards Universal Access* at 16.

22 SADC *Towards Universal Access* at 16.

23 SADC *SADC HIV and AIDS Business Plan* (2004) at 17.

24 See SADC *Subtheme on HIV and AIDS* (2006) at 10.

25 Our comments are based on the draft dated August 2007.

26 SADC *Towards Universal Access* at 4.

27 SADC *Towards Universal Access* at 9.

28 SADC *Towards Universal Access* at 16.

29 SADC *Towards Universal Access* at 16-17.

30 SADC *Towards Universal Access* at 18.

31 SADC *Towards Universal Access* at 19.

32 SADC *Towards Universal Access* at 19.

33 SADC *Towards Universal Access* at 20.

34 SADC *Towards Universal Access* at 20.

35 SADC *Towards Universal Access* at 21.

36 SADC *Towards Universal Access* at 21.

37 F Viljoen & S Precious *Human Rights Under Threat* (2007) at 11.

38 SADC *Subtheme on HIV and AIDS* (2006) at 6-7; SADC *Towards Universal Access* at 16-17.

39 See Section 3.2 above.

40 See discussion on page 21 above.

41 See concluding Section 5 below.

SECTION 5: CONCLUSIONS AND RECOMMENDATIONS

"The central message… is that a quarter of a century into the epidemic, the global AIDS response stands at a crossroads… In effect, for the first time ever the world possesses the means to begin to reverse the global epidemic. But success will require unprecedented willingness on the part of all actors in the global response to fulfil their potential, embrace new ways of working with each other and be committed to sustaining the response over the long term."

[Report of the Secretary-General *Declaration of Commitment on HIV/AIDS: Five Years Later* (2006) Summary]

1. Conclusions

1.1 Commitments undertaken by countries in Southern Africa

It is significant to note that the themes of gender inequality and the disempowerment of women as both a cause and a consequence of their vulnerability to HIV infection run like a golden thread through the documents reviewed in Section 3 above. These documents locate the AIDS pandemic beyond the health sector, and place it firmly in a developmental and human rights framework. Importantly, addressing gender-based violence as part of the AIDS response is often included as an aspect of the protection of human rights.[1] Closely linked to the concerns of gender inequality and discrimination is the undertaking by states, given explicitly in several of these documents, to address gender-based violence as a strategy to alleviate women's disproportionate vulnerability to HIV.

Some of the more recent documents, most notably the *Brazzaville Commitment* and the *Abuja Call for Accelerated Action*, further contain a frank assessment of the challenges and obstacles impeding the African response to AIDS. In addition to the high vulnerability of women and girls, these include a high dependence on external funding,[2] a failure to take into account the links between HIV/AIDS and sexual and reproductive health,[3] and poor or inadequate coordination of regional and national and international partnerships.[4] These observations are of particular significance for purposes of this study.

1.2 Existing frameworks

The international and regional commitments to deal with gender inequality, including gender-based violence, as one of the strategies to contain the AIDS pandemic constitute only an initial step of the process. The next step would be the translation of these political commitments into workable strategies and policies on regional, subregional and national level. Here, also, significant progress has been made in terms of the development of a subregional strategic framework on HIV/AIDS.

Our examination above of the *SADC Strategic Framework on HIV and AIDS* and its current operational plan, the *HIV and AIDS Business Plan,* shows that gender-based violence should be more strongly integrated. At the same time, the five main focus areas of the *SADC HIV and AIDS Business Plan* at present allow significant space for the recognition of and integration of activities related to gender-based violence. We list some examples below.

- *Policy development and harmonization:*
  An example here would be the harmonisation of policies relating to post-exposure prophylaxis (PEP) following sexual assault, which is also identified as a gap in the *Strategic Action Plan* on prevention.[5] (These policies will also have to be aligned with the draft *SADC Protocol on Gender and Development*, which requires state parties to ensure that survivors of sexual offences have ready access to PEP at all health facilities.)[6]

In terms of the *Strategic Action Plan* on prevention, this focus area also seeks to "negotiate regional consensus on essential elements and performance standards for key prevention interventions including communications for behavioural and social change".[7] It will be important to attempt to achieve this regional consensus for communication interventions aimed at addressing the intersections between gender-based violence and HIV/AIDS.

ℛ *Capacity development and mainstreaming of HIV/AIDS into all SADC policies and plans:* It is important to develop capacity, both on subregional and national level, to integrate gender-based violence into policy development where appropriate. The following example illustrates the significance of this integration on the level of policy development as well as building capacity of service providers:

Example:

In a recent study conducted by Human Rights Watch in Zambia, women disclosed to researchers that domestic violence at the hands of their husbands and intimate partners, and the fear of such violence, had a direct, harmful impact on their ability to start and continue using ART. The study also revealed that healthcare facilities providing ART have not adequately responded to gender-based abuses, including violence against women, in a way that would enhance women's access and adherence to ART. Healthcare workers responsible for monitoring adherence to ART are not required to probe for gender-based violence or other abuses as potential hindrances to successful treatment, nor are they adequately trained to do so. Although the relevant policies generally highlight the importance of gender in addressing health needs in Zambia, they seldom address gender-based violence. Existing health protocols do not cover gender-based violence. HIV treatment adherence counselors, other health professionals, and policy-makers, however, told Human Rights Watch that they would welcome programmes through which they could probe for and address gender-based violence in ART clinics, if adequately trained and equipped to do so.

[Human Rights Watch *Hidden in the Mealie Meal: Gender-Based Abuses and Women's HIV Treatment in Zambia* (2007) at 21, 41-42.]

While this example relates to the integration of gender-based violence into policy and programme development in *national* context, the same principle applies in the broader subregional environment.

ℛ *Facilitating a technical response, resource networks, collaboration and coordination*
A significant body of work on gender-based violence in Southern Africa is already in existence, and accessible resources (in the form of experts and existing networks) can be drawn upon. For example, new information is available on HIV prevention programmes such as the "Stepping Stones" programme, which was recently evaluated in a study conducted in the Eastern Cape, South Africa. The evaluation found that this programme can be effective in reducing the incidence of STI's, and may further be successful in limiting sexual risk taking and violence perpetration among young, rural African men.[8]

1.3 Funding and resources

A second theme that is omnipresent in the international and regional documents that we examined for purposes of Section 3, is that of funding and resources. In the *UN Declaration of Commitment* of 2001 the need to balance the garnering of financial support from the international community for HIV/AIDS prevention, treatment and support in developing countries with encouraging these developing countries to increase and prioritise national budgetary allocations for HIV programmes, is clearly acknowledged.[9] At the same time, the Declaration adds the caution that resources in the most heavily

affected countries are severely limited. Significantly, the Declaration therefore calls for debt cancellation for heavily indebted poor countries (in return for demonstrable commitments to poverty eradication).[10] The attempt to find this balance is also illustrated in the *Abuja Declaration* (2001),[11] with its pledge of allocating 15% of annual national budgets to improvement of the health sector, together with a call on donor countries to complement the "resource mobilization efforts" of African governments.[12]

Between 2001 and 2005, total financing for HIV programmes in developing countries increased more than fourfold.[13] The UN Secretary-General Report (2006) noted that in 2005, approximately $8.3 billion was spent on AIDS programmes in low- and middle-income countries, reaching the financing target in the Declaration of Commitment of between $7 billion and $10 billion.[14] Among 25 countries in sub-Saharan Africa, domestic public sector outlays on AIDS increased by 130% since the special session in 2001, reaching a total allocation of $640 million in 2005.[15] Despite this increase, per capita AIDS spending remained low in those countries (roughly $0.65).

Unfortunately, this report also observed that the rate of increase in HIV funding appeared to be slowing, underscoring the need to redouble leadership and commitment on HIV to generate the level of resources required to finance an effective response.[16] This appears to remain a difficulty, with the *SADC Strategic Action Plan* on prevention listing the mobilisation of resources needed for regional prevention efforts (as well as supporting the more efficient utilisation of resources already mobilised for interventions aligned to the regional strategy) as one of the challenges facing the subregional response.[17]

However, it is not simply the task of mobilising sufficient resources for carrying out the SADC *HIV and AIDS Business Plan* from both international and national sources, which predominantly rests with the SADC HIV and AIDS Unit, that deserves

our attention here. There is also the further question of how much of HIV/AIDS funding is allocated to gender-based violence work, both on subregional and national level. A recent survey conducted to analyse the policies, programmes and funding patterns of the four largest international public donors[18] to HIV/AIDS found that these multi- and bilateral agencies continue to treat gender-based violence as an "add-on" rather than as integral to all aspects to their HIV/AIDS work.[19] Separate funding and programme streams (to combat HIV/AIDS on one hand, and on the other, to eradicate violence against women and girls) means not only that there are far fewer resources allocated to efforts to address violence as a cause and consequence of HIV infection, but also that the strategic imperative for integrating these efforts continues to suffer from a "dangerous, dysfunctional and ineffective split".[20]

The study further found that, within policy and programmes, violence against women and girls is rarely highlighted as a major driver and consequence of the disease, nor measured statistically as a means of contributing to the evidence base.[21] This again emphasises the need for incorporating gender-based violence at strategic framework level, to ensure consistent inclusion in programme and, importantly, budget planning.

2. Recommendations

In this section, we set out a number of general recommendations. (In the interest of brevity, we have not divided these into recommendations to SADC bodies, governments or non-governmental organizations.)

The *Women Won't Wait Campaign* report referred to above sets out a model consisting of ten steps for institutions to first develop and then translate policy into action by constructing measurable means to integrate violence against women into HIV/AIDS programming. While all ten steps are important, the first five may be of specific relevance in the SADC context:

1. **Develop and articulate a clear policy framework that gives priority to violence against women and girls, HIV/AIDS and their linkages.** Violence against women and girls should be addressed across the HIV/AIDS prevention, treatment and care and support spectrum and translated into regional plans and country assessment and programming. It should provide specific programmatic guidelines and training for staff at headquarters and country level.

2. **Create a specific means for measuring work that addresses violence and all forms of discrimination against women and girls** in HIV/AIDS action plans, programming and monitoring and evaluation processes.

3. **Conduct a follow-up study** that explores the level of support for work that addresses the violence against women and girls and HIV/AIDS intersection at the field level, to assess what programming is taking place, by whom and to what effect. This will help to ensure that public commitments amount to real measurable and quantifiable integration.

4. **Encourage cross-issue collaboration** to help groups working on violence against women and girls and those working on HIV/AIDS work together and learn from each other.

5. **Investigate, document and fill the gaps.** While policy information about the intersection of violence against women and girls and HIV/AIDS exists and increases there is a need to strengthen the knowledge base. Epidemiological evidence is patchy, as is information about the relationship between input and outcomes, along with good practices and lessons learnt.

[Women Won't Wait Campaign *Show Us the Money: Is Violence Against Women on the HIV&AIDS Donor Agenda?* (2007) at 8-9]

In the context of the *SADC Strategic Framework* and the *HIV and AIDS Business Plan,* certain of these elements are already in place. However, as we have pointed out above, additional opportunities exist for identifying the "plausible areas for intervention" referred to by the Special Rapporteur on Violence Against Women and incorporating them into the *Business Plan.*[22]

In identifying these areas for intervention, it will be important to also have regard to the recommendations of the Task Force on Women, Girls and HIV in Southern Africa, which included (amongst others), recommendations to governments and development partners to -

֎ 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; and

֎ consider putting in place policies and procedures related to screening for violence against women and girls as part of all voluntary counselling and testing services.

Another potential area for intervention on SADC level is that of the development of model legislation, for example, on domestic violence.[23] Although certain countries in southern Africa, for example, South Africa,[24] Namibia[25] and Zimbabwe,[26] have enacted domestic violence legislation, this is an area for further exploration in terms of the linkages between gender-based violence and HIV/AIDS. The aspect of marital rape, specifically, needs urgent legislative intervention in several jurisdictions where it is not recognized as a criminal offence. In this regard, it is important to bear in mind that for many women, their risk factor for HIV infection is living with an HIV-positive husband or partner.[27]

We would argue that a clear understanding of the links between gender-based violence and HIV/AIDS, together with the political commitments undertaken as discussed above, provide compelling evidence for the criminalisation for marital rape. For example, in the *Abuja Call for Action* (2006), African governments undertake to enact laws to align them with AU frameworks, including the *African Protocol on Women's Rights*.[28] Similarly, as set out above, the UN Political Declaration (2006) contains a commitment to strengthening legal measures for the reduction of their vulnerability to HIV/AIDS.[29]

The year 2008 is one in which progress in the implementation of the Abuja Call for Action as well as the UNGASS Declaration of Commitment is to be measured. This is yet another area where subregional bodies may play an important role.

A next point of analysis will be to examine legislation and policy on *national* level in the fourteen SADC countries to determine the extent of linkage between gender-based violence and HIV/AIDS there. In South Africa, for example, the national *HIV and AIDS and STI Strategic Plan 2007-2011* includes as one of its goals to focus on the human rights of women and girls and "mobilise society to promote gender and sexual equality to address gender-based violence".[30]

This latter aspect is of significance, since we noted above how gender inequality increases women's vulnerability to HIV infection by limiting their access to a range of resources such as education, employment and housing.[31] More specifically, it also limits their access to HIV prevention, treatment and care services. These inequalities are acknowledged in the *SADC Strategic Action Plan* on prevention, which notes that "inequities in health systems within and across member states" leave significant segments of the population, for example, rural communities, untouched by prevention efforts.[32] These inequalities are exacerbated by violence against women, which is correctly described by Obando as "one of the most extreme manifestations of power inequality between women and men".[33] It will be difficult, if not impossible, to address the fundamental inequalities underlying women's vulnerability to both gender-based violence and HIV/AIDS without a clear understanding of how power (and women's disempowerment) feature in these interlinked phenomena.

In conclusion: we selected the title "At the Crossroads" for this publication to firstly emphasise the intersecting spaces of gender-based violence, HIV/AIDS and women's equality. Secondly, we want to draw attention to the "crossroads" referred to in the quotation from the UN Secretary-General's 2006 report included at the beginning of this Section – that in southern Africa particularly, it is time to make hard choices in order to align action with commitment.

1   See eg UNGASS *Declaration of Commitment on HIV/AIDS* (2001) at Par 61; UNGASS *Political Declaration* (2006) at Par 30.

2   *Brazzaville Commitment* at Par (b); *Abuja Call for Accelerated Action* at Par 7.

3   *Abuja Call for Accelerated Action* at Par 7.

4   *Abuja Call for Accelerated Action* at Par 7.

5   See SADC *Towards Universal Access to HIV Prevention: SADC Strategic Action Plan 2008-2010* (August 2007) at 16.

6   Art 22(2)(c) of the draft *SADC Protocol on Gender and Development* (dated August 2007).

7   SADC *Towards Universal Access* (above) at 20.

8   Medical Research Council Policy Brief *Evaluation of Stepping Stones: A Gender Transformative HIV Prevention Intervention* (March 2007).

9   See *Declaration of Commitment* (above) at Par 79-86.

10 Par 87.

11 When comparing the two documents, it is important to bear in mind that the *Abuja Declaration* preceded the *UNGASS Declaration of Commitment.*

12 Par 28.

13 *Declaration of Commitment on HIV/AIDS: Five Years Later – Report of the Secretary-General* UN Doc A/60/736 dated 24 March 2006 at Par 4.

14 Par 10(b). In 1996, when UNAIDS became operational, the world spent less than $300 million on HIV programmes - Par 46.

15 Par 48.

16 Par 50.

17 SADC *Towards Universal Access to HIV Prevention: SADC Strategic Action Plan 2008-2010* (August 2007) at 16.

18 These donors are the Global Fund to Fight AIDS, Tuberculosis and Malaria, the President's Emergency Fund for AIDS Relief (PEPFAR/US), the UK Department for International Development (DFID), and the World Bank. The work of UNAIDS, as the key international agenda-setting agency, was also included.

19 Women Won't Wait Campaign *Show Us the Money: Is Violence Against Women on the HIV&AIDS Donor Agenda?* (2007) at 2.

20 Women Won't Wait Campaign (above) at 2.

21 Women Won't Wait Campaign (above) at 2-3.

22 See Section 1 above.

23 See in this regard Viljoen and Precious *Human Rights Under Threat (2007)* at 12.

24 Domestic Violence Act 116 of 1998.

25 Combating of Domestic Violence Act No 4 of 2003.

26 Domestic Violence Act 14 of 2006.

27 See discussion on page 17; see also page 20, where the findings of the UN Secretary General's Task Force on Women, Girls and HIV/AIDS in Southern Africa are set out.

28 Art 4(2)(a) of the Protocol provides that States Parties must enact and enforce laws to prohibit all forms of violence against women, including unwanted or forced sex, whether the violence takes place in private or public.

29 Par 31.

30 Department of Health *HIV & AIDS and STI Strategic Plan for South Africa* (April 2007) at 15. This goal resorts under Key Priority Area 4, ie "Human Rights and Access to Justice".

31 See Section 2 at page 16 above.

32 SADC *Towards Universal Access* (above) at 9.

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