CHAPTER NINE

SOCIAL, HUMAN DEVELOPMENT AND SPECIAL PROGRAMMES (SHD&SP)

The SHD&SP Directorate covers areas of human development, health, employment and labour, education and training, culture and information and sport, HIV and AIDS, and special programmes, which include alcohol and drug abuse, science and technology. This is in line with SADC's overall goal of the social and human development intervention, which is to contribute to the reduction of human poverty and to improve the availability of educated, well informed, skilled, healthy, flexible, culturally responsive, productive and efficient human resources for the promotion of SADC's equitable economic growth, deeper integration and its competitiveness in the global economy.

Some of the key activities are organised around the implementations plans relating to key Protocols and commitments, such as the Protocol on Education and Training, the Protocol on Health, the SADC Charter of Fundamental Social Rights and the Maseru Declaration on HIV and AIDS, amongst other commitments.

The areas of focus in SHD&SP are at the core of gender equality concerns. For instance HIV and AIDS still has a female face in the region, and productive employment, considered a key source of income and women's empowerment, largely eludes a majority of SADC women There is good progress on gender parity in education at primary school level, but this proves to dissipate at secondary and tertiary levels. It has been noted elsewhere that gender parity in education must be accompanied by equality in terms of participation, thus issues of teenage pregnancy and sexual harassment still impact negatively on girls' education.

Case study 5: Gender in the delivery of basic services

The health minister of a Member State has asked SADC to assist in identifying blockages to service delivery in rural hospitals in the country. Teams comprising three women and three men each from SADC, a consulting company, and the ministry of health are set up to go and investigate the situation. The following is a description of the situation pertaining at one rural hospital:

Patients have been sleeping on the floor for up to two days awaiting medical attention. The majority of these are women and children. A man in the vicinity involved in a road accident died because the ambulance failed to pick him up on time. The ambulance is frequently seen parked outside the pub, and the driver is frequently drunk. He is a relative of the male clinic superintendent, and has not been disciplined. At the time he applied for the job, a female candidate was rejected on the grounds that "driving is a job for men." One of the reasons for congestion in the clinic is that the facilities are stretched. Over three quarters of the patients who are hospitalized are people living with HIV/AIDS.

The numbers have increased dramatically since the roll out of ARVs. Most of the hospitalized patients are women. There is a system of home-based care in the area, but the female care givers are paid R500 a month or have to work on a voluntary basis and this system is overstretched. Another factor affecting patient flow is the antiquated systems in use. All records are kept manually. The majority of clerical staff are women, and they have not been trained in use of IT equipment. One male doctor services the clinic, but he does not live in the vicinity. Most of the health care is provided by female nurses who earn R3000 a month. They work long hours, do not receive compensation for overtime, and are unhappy about their conditions of service, but these have not been looked into.

A case of sexual harassment involving the doctor and one nurse was reported to the provincial authorities but no action taken. This has added to the despondency among the female staff. When a rape survivor came to the clinic recently, after being violated by a well known businessman, the superintendent told her that the

hospital did not treat such cases. Feeling powerless to act, the women nurses watched this humiliation in the packed waiting room but said nothing. Although by far the largest beneficiaries of clinic are women, all the members of the governing council are men, and the local chief is the chair. There has never been a customer survey of services provided, nor have the concerns of patients who wait for days on end for service every been taken up.

1. What are the gender issues in this case study?

2. In what way are they affecting progress?

3. Analyse this case study using the framework overleaf:

REASON FOR POOR DELIVERY	GENDER DIMENSIONS	PROPROSED STRATEGIES	GENDER INDICATORS

Exercise 26: Finding Gender in SHD&SP spector programmes

Go through the SHD&SP business plan in light of the key gender issues in education, health, employment, HIV and AIDS identified earlier, and answer the following questions

1. Is there explicit reference to the key gender equality issues outlined in the key sectors?

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___

2. If yes, where, is this adequate in line with requirement for gender mainstreaming?

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___

3. Would you describe SHD&SP plans as gender blind, gender neutral or gender aware?

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4. What steps can be taken to ensure that the business plan is gender aware?

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Notes

Gender responsiveness is evident in some area of programme focus in the Directorate. A review of the HIV and AIDS Unit's (the Unit) 5 year business plan, for example, shows a sensitivity to gender equality issues and concerns, including analysis of the problems and in its key principles recognises gender mainstreaming and notes that 'it is understood that the relationship between men and women are integral to the development of an effective response to the epidemic'. There are 5 key intervention areas, which focus on policy development and harmonisation, capacity building and mainstreaming HIV and AIDS into all policies and plans, facilitation of a technical response, resource networks, collaboration and coordination, resource mobilisation, and monitoring and evaluation of the region's multi sectoral response. It is interesting to note, however, that the gender equality principle is not precisely followed to its logical conclusion in terms of strategic programme direction, so it does not surface in all the outputs envisaged under each intervention area.

Progress has been made by the Directorate, though the Unit, to integrate HIV and AIDS issues and concerns in other programmes, such as water resource management, agriculture and other areas key in regional integration; this is in line with the Unit's work to develop sectoral policies. Some commendable work has been done and some important lessons can be learnt that will inform gender mainstreaming work in the Secretariat, including the inter Directorate structures for facilitating mainstreaming. Importantly the Unit is also spearheading the adoption of the Workplace HIV and AIDS policy mentioned earlier in this report, and some synergies can be created between that process and the anticipated development of a Workplace Gender Policy.

Exercise 27: Finding SHD&SP in gender instruments

Go through the instruments listed below and any others that you may regard as relevant. What provisions are made that are relevant to your sector?

Instrument	Relevant provisions for gender mainstreaming
Millennium Declaration and Millennium Development Goals – Goal 1 and 3 (2000)	
Convention on the Elimination of All Forms of Discrimination Against Women (1979)	
Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (adopted 2003)	
The SADC Protocol on Education	
SADC Regional Gender Policy SADC Declaration on Gender and Development (1997)	
Draft SADC Protocol on Gender and Development	
Declaration on HIV and AIDS	
Other legal or policy instruments relevant to the sector	

Notes:

The SADC Gender Policy has identified 16 interventions aimed at increasing women, men, girls and boys' access to education and training programmes in order to enhance human capital development in the region, and 13 seeking to contribute to better health in SADC through responsive health delivery, research and public education policies that are gender sensitive and address women's empowerment. The SIF has identified specific actions required to ensure equal access to education, eradicating illiteracy, challenging stereotypes and sexual violence in education, developing quality infrastructure. With regard to sexual and reproductive health and HIV and AIDS, issues such as improvement of health services, including maternal health, addressing sexual rights, addressing negative cultural practices and customs perpetuating women's vulnerability to HIV and AIDS are key areas of action, with specific targets in line with MDGs, amongst other commitments.

Action planning

Exercise 28: Think through all the different programme areas of SHD & SP. Identify at least one gender issue in each programme area of focus and an action that could be taken to address this.

AREA OF WORK	GENDER ISSUES	ACTIONS
CULTURE AND INFORMATION		
HEALTH AND PHARMACEUTICALS		
HIV and AIDS		
Policy Development and harmonisation		

AREA OF WORK	GENDER ISSUE	ACTION
Capacity Building and HIV and AIDS Mainstreaming		
Facilitation of a Technical Response, Resource Networks, Collaboration and Coordination		
Resource Mobilisation for the Regional Multisectoral response		
Monitoring and Evaluation of the Regional Multisectoral response		
EDUCATION, SKILLS DEVELOPMENT & CAPACITY BUILDNG		
EMPLOYMENT, PRODUCTIVITY, LABOUR, SOCIAL SECURITY		
SPECIAL PROGRAMMES		

Fact sheets and checklists

The fact sheets and checklists that follow will assist in developing relevant gender action plans.

Fact Sheet 13: Key gender issues in education

Female education is the investment with the highest social return and the catalyst that increases the impact of other investment in health, nutrition, family planning, agriculture, industry and infrastructure[44]. It has been pointed out that "education and gender equality are intended to place girls in control of their own destinies and achieve greater parity between men and women in the spheres of economic growth, poverty reduction and overall human development"[45]. In the current era of globalisation, economic growth depends increasingly on an educated workforce that is poised to take advantage of opportunities. The enhancement of people's capabilities, in particular women's capabilities through education, therefore, opens chances for women to participate in the labour market or to look for more decent employment opportunities, and it is of critical importance in efforts to achieve poverty reduction[46].

While adult literacy rates in the SADC region are relatively higher than in other parts of Africa, the table below shows that, except for Botswana and Lesotho, women in the region generally have lower literacy levels than men. Nonetheless, SADC Member States have made great strides at the primary and secondary education level where gender parity has been reached or is likely to be reached. The major challenge in the region remains at the tertiary level where, despite overall improvements, gender inequality in enrolment still persists. In 2004, seven out of the 13[47] SADC countries for which data was available (Angola, Botswana, Madagascar, Malawi, Mozambique, Tanzania and Zambia) showed a lower rate of enrolment at the tertiary level for girls than boys,while Lesotho, Mauritius, Namibia, South Africa and Swaziland had a bias against boys[48].

44 http://www.worldbank.org/afr/findings/english/find85.htm accessed 25th February 2008.
45 Naidu, S., Roberts, B. and Humphries, R. (2004). 'Achieving the Millennium Development Goals in SADC'. SADC Barometer. Issue 7
46 ILO (2007). Global employment trends for women: Brief March 2007. Geneva: International Labour Organisation.
47 Data was not available for the DRC.
48 Chipika, J.T. (2007). It is almost half-time": Will the SADC region achieve the Millennium Development Goals (MDGs) by the target date of 2015? Paper presented to the Southern African Regional Poverty Network. Johannesburg June 2007.

	Free Education[49]			Mandatory Attendance Age	Gender Dissaggregated Literacy Rate		National Literacy Rate
	Primary	Secondary	Tertiary				
Angola	No	No	No	----	82.1%	53.8%	66.8%
Botswana	✓	FEA	GFLA	----	76.9%	82.4%	79.8%
DRC	----	----	----	----	76.2%	55.1%	65.5%
Lesotho	----	----	----	----	74.5%	94.5%	84.8%
Malawi	----	----	----	----	76.1%	49.8%	62.7%
Mauritius	✓	✓	✓	16 years	88.6%	82.7%	85.6%
Madagascar	----	----	----	----	75.5%	62.5%	68.9%
Mozambique	----	----	----	----	63.5%	32.7%	47.8%
Namibia	✓	FE/OVC	GFLA	----	84.4%	83.7%	84%
South Africa	✓	No[50]	No	14 years	87%	85.7%	86.4%
Swaziland	GFLA	GFLA	GFLA	----	82.6%	80.8%	81.6%
Tanzania	✓	GFLA	GFLA	----	85.9%	70.7%	78.2%
Zambia	✓	FE/OVC	No	----	86.8%	74.8%	80.6%
Zimbabwe	✓	No	No	----	94.2%	87.2%	90.7%

Source: https://www.cia.gov/cia/publications/factbook/index.html National Progress Reports from Member States, 2006

Key: ---- - Information not available
FEA - Fee Exemptions Available
GFLA - Government Funding or Loans Available
FE/OVC - Free Education for Orphans and Vulnerable Children

Challenges to achieving gender equality in education remain, including the introduction of user fees in some countries resulting in girls, and increasingly boys, dropping out of school. There are higher drop out rates for girls due to early pregnancy or marriages, and increasingly the need to head households due to the impact of HIV and AIDS. Some countries still discriminate against girls who fall pregnant and whilst in theory most can resume their education after giving birth, the reality is different. In Zimbabwe Teachers' Colleges, a policy has been adopted (1997) encouraging female students to stay in college when they get pregnant (unless this is not possible for health reasons). Similarly, in October 1999, the Zimbabwe Ministry of Education, Sport and Culture adopted a policy to regulate the granting of leave to girls who fall pregnant in primary and secondary schools and their re-enrolment after delivery. In Namibia, pregnant teenagers are required to leave school, with few returning. A girl who becomes pregnant is, by law, allowed back to the same public school after one year's absence. The government of Zambia continues to implement and enforce a re-entry policy allowing girls who fall pregnant to return to school.

In general the information available shows poor performance by girls at secondary school level, and a higher intake rate of boys than girls at tertiary levels. There are still strong gender biases in fields of study at tertiary and vocational levels, with girls and women slowly moving into the sciences and other technical fields, but still dominating the traditionally 'female' fields.

Other critical issues that require policy, legislative and other interventions by SADC Member States include the need to upscale sex education in schools, mainstreaming gender into school curricula, and addressing

[49] It is important to remember that even when education is offered free of charge, many families are still burdened with many fees including: text books, uniforms, school maintenance fees, tutoring costs, etc.
[50] It is important to note that South Africa is currently working towards free education with the Plan of Action on Improving Access to Free and Quality Education for All (2003).

teacher prejudices based on gender biases. Improved sanitation facilities are necessary, particularly for girls who may sometimes fail to attend school a number of days a year due to their absence. Sexual assault and harassment in schools, amongst students and by teachers is a serious problem in most SADC countries and requires urgent attention. This is exacerbated by the practice of virginity testing and the impact of transactional and inter-generational sex, increasing the rate of HIV infection amongst the youth, in particular young girls[51].

Member States have the enormous task of bridging the gap between gender parity in education, where most have scored success in terms of enrolment rates between boys and girls, and gender equality in education, which addresses the quality of education being provided. The issues outlined point to enormous challenges with reaching the Millennium Development Goals (MDGs) 2 and 3 of eliminating gender disparities at all levels of education by 2015. The response must be towards strengthening policy, legislative and programmatic interventions, coupled with mainstreaming key gender equality concerns in a multi sectoral way, so that interventions are mutually reinforcing.

According to the SADC Gender Policy, the region's focus in addressing gender equality in education is to increase women, men, girls and boys access to educational and training programmes in order to enhance human capital development in the region. This premise of this focus is that education is a human right, and that non discriminatory education ultimately benefits both women and men, and contributes significantly towards addressing inequality. Equally important is the fact that the education system is an important avenue for the transmission of knowledge, skills, and information, but also societal values relating to gender equality.

The region also adopted a 2007 Regional Implementation Plan on Education and Training (2007 – 15). This is in line with the Second Decade o Education and other commitments, including Education for All (EFA). It focuses on nine priorities, namely Education Management Information Systems, quality improvement and management, higher education, teacher education, technical and vocational education and training, curriculum development including teaching and learning materials, quality assurance and qualifications frameworks, open and distance learning, mainstreaming gender, culture, HIV and AIDS and ICT. Member States are therefore required to develop national action plans in alignment with this regional plan.

The challenge is to ensure there is coherence and alignment between the various commitments and plans, so that both gender parity and equality in education is achieved, meaning that improvements in rates of enrolment of girls and boys (access), must be accompanied by an enabling environment (participation), which is empowering and contributes to gender equality (transformation). This includes freedom from sexual harassment and sexual assaults, gender sensitive curricula, non gender biased teachers, access to adequate facilities including infrastructure, protecting the rights of pregnant school girls, as well as squarely addressing structural causes of inequality, including parental biases towards boys' education. This extends also to ensuring that girls move into the non traditional fields of study with the right support, with SADC governments addressing some of socio economic and cultural barriers to education.

[51] Tolmay, S (2005) – Audit of the SADC Declaration on Gender and Development – Education- www.genderlinks.org.za accessed 19.05.08.

Checklist

- ✓ Has gender been mainstreamed into national goals and plans on education, linked to MDGs and other regional and international targets?
- ✓ Has there been a review of education curricula, equal access to educational opportunities and an emphasis on science and mathematics; establish mechanisms for girls to study science and mathematics?
- ✓ Have gender stereotypes in education and training been eliminated?
- ✓ Have affirmative action measures been adopted to increase access to quality education by girls and women, including tertiary education and especially in non traditional fields of study?
- ✓ Are there special scholarship programmes for girls and women at national and regional levels?
- ✓ Are there role modelling exchange programmes in SADC for enhancing girls' education?
- ✓ Is there advocacy for increasing girls' enrolment and retention in schools to address the gender gap between girls and boys, and public education in promotion of girls' education?
- ✓ Is there a regional adult literacy campaign programme to promote skills training and capacity development, in particular management training for women?
- ✓ Have measures been taken to increase girls' access to education, children with special needs, and persons with a disability?
- ✓ Does the private sector to invest in education, in particular girls' education?
- ✓ Is there vocational training for women and girls, particularly in non traditional fields, and create new job opportunities for women
- ✓ How is gender based violence in schools being addressed?
- ✓ What strategies have been developed to address the long term impact of HIV an AIDS on orphans', girls' and women's education?
- ✓ Have women's rights been integrated into education programmes?

Additional resources:

Gender Tipsheets (Education) - Development Co-operation Directorate (DCD – DAC)
http://www.oecd.org/document
Tolmay, S (2005) – *Audit of the SADC Declaration on Gender and Development — Education-*
www.genderlinks.org.za
Naidu, S., Roberts, B. and Humphries, R. (2004) 'Achieving the Millennium Development Goals in SADC'. *SADC Barometer. Issue 7*

Fact Sheet 14: Key gender issues in employment

The SADC Gender Policy links gender equality in employment to economic empowerment and poverty eradication. Women's employment is a cornerstone of economic rights, which also includes appropriate working conditions and control over economic resources. SADC's policy commitment is to 'enhance economic empowerment initiatives to ensure that all women and men benefit from increased economic opportunities in trade, formal and informal employment and business'. In particular, Member States also commit to integrate women's unpaid work into national accounts and budgeting processes.

These policy commitments set the tone for addressing a number of far reaching challenges in seeking to redress gender inequality in the employment sector. It is noted[52] that one of the most striking labour market trends of recent times is the growing proportion of women in the labour force and the narrowing gap between male and female participation rates. In the SADC region, the share of women in wage employment in the non-agricultural sector increased between 1990 and 2004 in Botswana, Mauritius Malawi, South Africa and Zimbabwe. However, as in the rest of Africa, this share remains low ranging from a minimum of 13 percent in Malawi to a maximum on 49 percent in Namibia. Most women have remained in agricultural, household informal sector/household business and in unpaid household work.

In Lesotho there is relative equality in terms of gender balance in formal employment. At the same time unemployment is a gendered problem, with 36% of women unemployed while only 25% of men lack formal employment. In addition to this, women in Lesotho often have to leave the country in order to find work; about one fifth of working Basotho women are today employed outside the country[53].

In Mauritius there are significant changes in the occupational and sectoral distribution of the female labour force (with women experiencing a rising share in services and manufacturing and a declining share in agriculture and domestic service), but there is still both horizontal and vertical segregation of occupations by gender. Factors which have promoted labour force participation of women are: fertility reduction, increased life expectancy, economic hardships and wider opportunities beyond the confines of family and home. On the other hand, the main factors constraining higher participation are: resistance by some family members to women's participation in paid employment, inability to make arrangements for childcare, housework demands, nurturing within the household, reproductive responsibilities and difficulties in managing the interface between home and work.

In Namibia women are highly represented in unpaid subsistence activities, while men take part in waged work. For example, of female headed households, 44% of female headed households depend on subsistence agriculture, while only 28% make a living from wage employment. At the same time, more than 50% of men depend on wage labour and only 29% from subsistence farming. Clearly, when it comes to receiving a regular and reliable income, women are under represented.

In Zambia, over time the formal sector has been steadily diminishing as the main source of employment in Zambia - from 75% in 1975 to 10.3% in 1999. Women have been the most affected by the erosion in sectoral employment opportunities. The share of women in formal employment has drastically reduced

[52] SADC (2008) Gender and Development for Poverty Eradication (draft)
[53] SADC Gender Unit (2007:22) Regional Progress Report on Implementation of the SADC Declaration on Gender and Development

during the period of structural adjustment while informal sector activities have increased. A large number of women are thus engaged in low paying and less productive jobs in the informal sector in urban areas, while another large group of women are engaged in small scale farming in rural areas.

From this the trend is that women are over represented in informal and unstable employment. In addition, women are used as a reserve army of labour, as seen in Mauritius. When there is severe economic hardships women are brought in as wage workers to ensure that the basic needs of the family are met. Finally, even when women are employed in the formal sector, they often take up the lowest ranking positions and thus when jobs are cut women are the first to experience job loss (in other words, women are often "the last hired and the first fired"). There are, however, positive measures that can be taken to reverse the trends. While the concept of equity and equality must be established in the world of work, it is also vital that women be provided with wide opportunities for both stable employment and skills development.

Statistics for Women in Formal Employment

- Information in form of percentages from those countries reporting statistics

	Lesotho[54]		Mauritius[55]		Namibia[56]		Zambia[57]		Zimbabwe[58]	
	M	F	M	F	M	F	M	F	M	F
Education	33.3	66.7	90.8	9.2	52	48	----	----	59.2	40.8
Health	35.3	64.7	94.9	5.1	15	85	----	----	57.7	42.3
Agriculture, Hunting, Fishing & Forestry	76.1	23.9	91.5	8.5	62.5	37.5	45.3	54.7	44.4	56.6
Sales & Services	30.7	69.3	79.6	20.4	42	58	45.	54.5	46.4	54.6
Mining & Quarrying	77.8	22.2	99.9	0.1	88	12	100	0	93.3	6.7
Manufacturing	31.1	68.9	----	----	84	16	----	----	74.9	25.1
Electricity, Gas, & Water	45.5	50.5	99.9	0.1	----	----	100	0	----	----
Construction	58.5	41.5	99.6	0.4	88	12	100	0	93.7	6.3
Private Household Employees	13.8	86.2	----	----	----	----	----	----	45.4	54.6

Source: National Progress Reports from Member States, 2006

Although women's unpaid work creates a foundation for all other economic, political and social life, it is not counted in the System of National Accounts (SNA) and hence remains economically "invisible". Indeed 66 percent of women's activities in developing countries are not counted in the SNA while only 24 percent of men's activities are left out[59]. This "invisibility' means that women's work tends not to be regularly and systematically considered in public policy and in budgetary allocations thus exacerbating women's poverty situation.

[54] Source: Labour Force Survey 1999
[55] Provisional estimates
[56] Source: Employment Equity Commission: 2004/2005
[57] Source: CSO LCMS (IV) 2004
[58] Source: 1999 Indicator Monitoring Labour Force Survey: Central Statistics Office – July 2000
[59] SADC (2008) Gender and Development for Poverty Eradication (draft)

Numerous time-use studies have also shown that women work longer hours than men, when both market and non-market activities are taken into account. This is especially true for poor women who do not have resources to hire additional labour to take over some of the household responsibilities as they engage in market activities. This point is particularly relevant given the wide evidence that, while women are entering the formal sector in increasing numbers, their domestic workloads have not declined. They continue to be primarily responsible for such activities as the care of minor children and the elderly members of the household, cooking and cleaning, fetching water and firewood and managing the household in general.

In the SADC region, women earn less than men, as shown in the table below:

Country	Estimated earned income Femal (PPP US$*)	Estimated earned income (Male (PPP US$)
Angola	1 787	2 898
Botswana	5 913	19 094
Congo, D.R.	488	944
Lesotho	2 340	4 480
Madagascar	758	1 090
Malawi	565	771
Mauritius	7 407	18 098
Mozambique	1 115	1 378
Namibia	5 527	9 679
South Africa	6 927	15 446
Swaziland	2 187	7 659
Tanzania	627	863
Zambia	725	1 319
Zimbabwe	1 499	2 585

Source: Human Development Report, 2007 data accessed at http://hdrstats.undp.org on 27 February 2008

1. Except for Botswana and Swaziland, no other country had wage data. For the purposes of calculating the estimated female ad ale earned income, a value if 0.75 was used for the ratio of the female non-agricultural wage to the male non-agricultural wage.
2. * Purchasing Power Parity (PPP) - A rate of exchange that accounts for price differences across countries allowing international comparisons of real output and incomes. At the PPP US$ rate, PPP US$1 has the same purchasing power in the domestic economy as $1 has in the United States.

The steadiest source of non-agricultural employment for women in sub-Saharan Africa has been the informal sector, defined as all income-earning activities outside of legally regulated enterprises and employment relations. The informal sector in Africa is dominated by trade-related activities, with services and manufacturing accounting for only a small percentage of this sector. Most informal sector workers are self-employed, with only 30 percent of workers in wage employment. Street vending is one particular informal activity that is often self-employed. Many women are also informally employed as home-based workers.

Although statistics on the informal sector are unreliable by virtue of the subject, there is evidence that this is the ever expanding sector where most Africa people, particularly women, are employed. For example, a UNECA report stated that only 5-10 percent of new entrants into the labour market in Africa can be absorbed by the formal sector, with the bulk of new jobs being generated by the informal sector.

Although the informal sector has emerged as an important strategy for women to contribute to family income, the sector, for the most part, suffers from a lack of systematic and regular support in the form of official policies and resources. The informal sector in Africa is also characterised by low productivity and a higher prevalence of poverty among its workers. This is largely due to the fact that a high proportion of workers in this sector have low levels of education and literacy. In South Africa, for example, 37 percent of workers in the informal sector have not completed primary education compared to only 16 percent in the formal sector.

The informal sector is also characterised by low earnings. For example, research findings from five African cities showed that a high proportion of informal sector workers earn less than the minimum wage (UNECA, 2005), while the ILO has shown that wages in the informal sector are, on average, 44 percent lower than in the formal sector. Informal sector workers have also been found to typically work longer hours than those in the formal sector. Furthermore, informal sector workers are extremely vulnerable for three basic reasons: (1) they generally live and work under harsh conditions that are more commonly associated with shocks such as illness, loss of assets, and loss of income; (2) they have little or no access to formal risk-coping mechanisms such as insurance, pensions and social assistance; (3) given their low average levels of income and other resources such as proper housing and education, they are less able to cope with these contingencies.

Checklist

- ✓ Do policies promote opportunities, rights protection and the voice of women in the informal economy through the establishment of informal women workers organisations?
- ✓ Are women represented in policy making, collective bargaining negotiations and trade policy negotiations?
- ✓ Are there economic literacy programmes for women, as well as entrepreneurial skills in order to support critical understanding of business, trade and economic policies?
- ✓ Have discriminatory practices towards female workers in formal and informal employment in national and international labour markets, and promote health and safety regulations, including worker's rights and sexual harassment codes?
- ✓ What mechanisms exist to facilitate information exchange among women in financing, technological, and skills development in entrepreneurship and other business development services?
- ✓ In what ways are best practices of female entrepreneurs and employment rights and conditions being documented and disseminated?
- ✓ Is there a regional strategy for conducting time use studies and develop indicators to account for the work performed by women as unpaid work in national accounts?
- ✓ Are policy and legislative measures addressing employment equity and equality issues?
- ✓ Are women's rights in formal and non formal employment addressed in policy provisions, taking into account women's productive and reproductive roles?
- ✓ Are mechanisms in place and is there positive action to ensure that women have access to full and equal participation in the formulation of policies and definition of structures? (Ministries of Finance and Trade, National Economic Commissions/Institutes)?
- ✓ Is legislation enacted and enforced to promote the rights equal pay for equal work or work of equal value?
- ✓ Are equal opportunity laws in place, and has positive action been taken to ensure compliance by the public and private sectors?
- ✓ Is the legal system addressing discrimination in the labour market, including hiring and promotion, the extension of employment benefits, social security, and working conditions?
- ✓ Does the labour law protect the right to organise and access justice, as well as safe working conditions, including prohibiting forced labour?
- ✓ Are income tax and social security gender responsive? Are measures in place to reduce gender bias?
- ✓ Are measures in place to promote the rights of and regulate the role of women in the informal economy?
- ✓ Are there measures to promote economic literacy of women, access to credit facilities, removal of barriers to accessing economic opportunities?
- ✓ Is there routine collection of sex disaggregated statistics of participation of women and men in the informal and formal economy? How does this inform policy?
- ✓ Is there a policy in place addressing unremunerated work, particularly care work, work in family businesses, farms?
- ✓ Are national policies related to international and regional trade agreements protecting women's new and traditional economic activities from the impact of these agreements?
- ✓ Has there been a gender analysis of the employment sector budget?

Fact Sheet 15: Key gender issues in health[60]

The gender and health domain addresses a range of interconnected issues encompassing sexual and reproductive health rights. It has been pointed out that "sexual and reproductive health is the centre of life". The definition of sexual and reproductive health has been expanded to go beyond health care and service access to issues of sexual rights. The International Conference on Population and Development (ICPD) in 1994, defined reproductive health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its function and processes". On the other hand sexual health has been defined by WHO as "a state of physical, emotional, mental, and social well-being related to sexuality", and that for sexual health to be attained and maintained the sexual rights of all persons must be respected, protected and fulfilled."[61]

Key challenges to attaining sexual and reproductive health are HIV and STIs, unintended pregnancy and abortion, infertility and cancer resulting from STIs and sexual dysfunction. The SADC Region also experiences a diverse but largely high infant mortality rates. Of concern are countries such as Angola and Mozambique, where there are 185.36 and 129.24 deaths per 1,000 live births respectively[62]. On the other hand, countries like Mauritius experience a mere 14.59 deaths per 1,000 live births. Namibia and Zimbabwe also have low infant mortality rates with14.59 and 51.71 deaths per 1,000 live births respectively[63].

With regard to fertility rates for SADC Member States, the numbers range from an average of 6.45 children born per woman in DRC to 1.95 children born per woman in Mauritius[64]. The table below highlights some data in the key areas of concern[65].

60 Information from this section is drawn substantially from SAFAIDS (2005) SADC Declaration on Gender and Development – Sexual and Reproductive Health
61 WHO (2002) WHO Draft working definition, October 2002
62 SADC Gender Unit (2007:35) Regional Progress Report on Implementation of the SADC Declaration on Gender and Development
63 ibid
64 ibid
65 ibid

Statistics on Gender and Health

	Infant Mortality Rate	HIV and AIDS			Life Expectancy Rate		Fertility Rate
	Deaths per 1,000 lives Births	Adult Prevalence Rate	PLWHA	AIDS Deaths	Male	Female	Average Children Born per Woman
Angola	185.36	3.8%	249,000	21,000	37.47	39.83	6.35
Botswana	53.7	37.3%	35,000	33,000	33.9	33.56	2.79
DRC	88.62	4.2%	1,100,000	100,000	50.01	50.94	6.45
Lesotho	87.24	28.9%	320,000	29,000	35.55	33.21	3.28
Malawi	94.37	14.2%	900,000	84,000	41.93	41.45	5.92
Mauritius	14.59	0.7%	700	<100	68.66	76.66	1.95
Madagascar	75.21	1.7%	140,000	7,500	54.93	59.82	5.62
Mozambique	129.24	12.2%	1,300,000	110,000	39.82	39.53	4.62
Namibia	48.1	21.3%	210,000	16,000	44.46	42.29	3.06
South Africa	60.66	21.5%	5,300,000	370,000	43.25	42.19	2.2
Swaziland	71.85	38.8%	220,000	17,000	32.1	33.17	3.53
Tanzania	96.48	8.8%	1,600,000	160,000	44.93	46.37	4.97
Zambia	86.84	16.5%	920,000	89,000	39.76	40.31	5.39
Zimbabwe	51.71	24.6%	1,800,000	170,000	40.39	38.16	3.13

Source: https://www.cia.gov/cia/publications/factbook/index.html

Gender inequality and gender-based violence also impact significantly on the attainment of sexual and reproductive rights for women and girls. In terms of accessibility to health care, many national governments, in collaboration with non-governmental organisations (NGOs), have recognised maternal and reproductive health as a priority. In many SADC countries such as Malawi, pre-natal and post-natal care, birthing and early childhood care are offered in rural health centres and rural hospitals. The emphasis on improving maternal health care has also been shown in the increased number of births attended by trained health professionals.

However, very few of the SADC Member States provide these services free of charge. With limited access to resources, women tend to be among the poorest in the population. They may not be able to afford the treatment. Primary health care services and maternal health care services need to be provided free of charge. The issue of access to health care services for women in prisons and refugee camps, are often neglected and require attention.

There is also increasing evidence for the benefits of involving men as partners in family planning and reproductive health since it is the men who traditionally have the final say over such matters. Taking into account the relationship between violence against women and women's sexual and reproductive rights as well as the decision-making power of men in the household, men become vital partners in the response to HIV infection and issues such as access to services and reproductive rights. The knowledge and attitudes of men are very important and women need their support as they make choices about accessing sexual and reproductive health.

In terms of rights, the right to choose to when and who to marry is critical, as well as equal partnership and protection of women's right to bodily integrity in the marriage. This also extends to the right to choose the form of contraception to use, and the power to control fertility. Although the Protocol to the African Charter

on Human and Peoples' Rights on the Rights of Women in Africa (Women's Rights Protocol)[66] distinctly highlights this right, the dual legal system in the majority of southern African countries (10 of 12 countries) presents a challenge. For example, the Marriage Act in Zambia states that statutory marriage provides equal status between men and women, yet if a Zambian woman marries under customary law, she has minority status in relation to her husband. The minority status means that she may have less decision making power regarding decisions about her own sexual and reproductive health, as well as decisions about having children, child care and divorce.

Protection of sexual and reproductive health rights extends to the right to access accurate information and education on reproductive and sexual health, eliminating harmful traditional practices, addressing domestic violence and sexual assaults, HIV and AIDS including access to voluntary counseling and testing (VCT), access to anti retro virals (ARVs), as well as post exposure prophylaxis (PEP). Although most countries are in the process of scaling-up ARV treatment, more awareness and research is needed to understand the gender dimensions within HIV/AIDS care and treatment. Across the region, there are more women than men who are HIV positive hence there is a need to recognise the differences in providing care and ARV treatment for women.

The majority of member states are implementing Prevention of Mother to Child programmes. While there is a need to continue to scale up the programmes, this is seen as a positive step to reducing the risk of HIV infection for the child. However, there is a need to consider the health of the mother, by ensuring that after she has delivered, she is able to receive ARV treatment, free of charge. These are known as PMTCT Plus Programmes and more member states should be encouraged to make these programmes more widely available. Equally, PMTCT is often directed at the mother; there is a need to encourage men to become more involved in PMTCT and antenatal care. Mental health is often neglected yet psychological issues play a role in the decision to take up provided services.

The right to health entails enjoying the highest attainable standard of physical, social and mental health. SADC's policy commitment, as highlighted in the SADC Gender Policy, is to 'promote equality of access to and control over health care services in order to accord women as well as men their rights to physical, social and mental health'. The key objectives include improvement of health through gender responsive health service delivery, research, and public education aimed at promoting equity and equality in the eradication of diseases, including malaria, tuberculosis, HIV and AIDS, and sexual transmitted infections.

Health care and health status is influenced not only by biological and genetic factors, but also other socially constructed attributes, as well as socio economic factors such as poverty. Men and women's experience of health is different, and health status related to cultural norms can include issues concerning sexuality and reproductive behaviour, including women's ability to control their bodies and negotiate their sexuality. Factors such as status associated with child bearing can have a powerful impact on women as regards early, frequent and poorly spaced pregnancies, with resultant consequences.

Aside from a broad range of challenges requiring to be addressed, from HIV and AIDS to domestic violence and negative/harmful cultural practices, malnutrition and maternal mortality, there must also be a focus on the less visible impact of gender inequality on health. For example, higher exposure to environmental hazards as a result of the gender division of labour and occupational segregation, e.g women exposed to household chemicals, whilst men suffer from accidents related to work in construction or engineering.

[66] Full document on CD ROM

Checklist

Household activities

- ✓ What is the gender division of labour amongst the client population? How are the productive and reproductive roles interrelated? Data should show differences in roles between older and younger women and men, and between boys and girls. In other words who dies what, where, how, when, and for how long?
- ✓ What are the broad income levels of the client population? Are there differences in income between women and men?
- ✓ Identify key facts about the social structure and organisation (community organisation, cultural perception and attitudes, marriage rules, land ownership patterns), by gender and socio economic status.
- ✓ What services (health, education, water, infrastructure) are provided in the project area and to whom? Consider differences in socio economic status as well as gender
- ✓ What is the legal status of women? Do women have rights to self determination (e.g divorce, property rights, custody of children, decisions on reproductive matters)
- ✓ What is the status regarding access to health care providers?

Health status of the project population

- ✓ What are the most serious illnesses in the project area(s)? Are there gender differences in the incidence of particular diseases? What are the main causes of these illnesses (consider sanitation, diet, activity patterns)? What factors other than reproductive contribute to gender differences in the incidence of disease?
- ✓ What are the occupational health hazards in the targeted community? Consider exposure to pesticides, toxic waste materials? Are there gender differences? Are there particular risks to pregnant or lactating women?
- ✓ What is the extent of women's workload, and are patterns of sickness amongst women (malnutrition, anaemia and other diseases) explained by their occupational context?
- ✓ What information exists and can be collected regarding the mental health of women and men? Are there gender related differences in incidence?
- ✓ What roles do women and men play in community health care?
- ✓ How do women and men explain common diseases and health problems?
- ✓ Who makes decisions in families about taking children to a health care provider for treatment? Who decides whether medicine should be provided?
- ✓ Does the project mainly emphasise women's health in terms of their role as mothers? Is there a need for a broader focus on women's health?

Diet

- ✓ What kind of diet is common in the client population? Do women and men, girls and boys have different access to food?
- ✓ Is food bought or grown? Are changes from subsistence to cash production affecting food supply or changing dietary patterns? What is the significance of the health status of women and men?
- ✓ For how many months do women usually breastfeed their children? What are the cultural attitudes towards the duration of breastfeeding? Is bottle feeding a common practice? What socio economic factors lead to decisions to bottle feed infants?
- ✓ According to cultural beliefs, is breastfeeding during pregnancy an acceptable practice?
- ✓ Are there food taboos for women during pregnancy and lactation?
  Are there differential patterns of growth between boys and girls in the same age group? Different diseases?

Are these differences related to differential feeding patterns of girls and boys or other factors?
- ✓ What is the incidence of anaemia among pregnant women in the target population?

Reproductive health
- ✓ What is the incidence of maternal deaths? What are the main maternal risk factors? What are the major clinical, environmental and socio economic causes? Which age groups are most at risk? What percentage of births is assisted by medically trained personnel?
- ✓ What are the child bearing years of women?
- ✓ What health problems among the client population predominantly affect women or are male specific?
- ✓ Is violence against women prevalent in the project area? What community or health services are offered to abused women?
- ✓ Are there women to women services in maternal and child health programmes (including reproductive health and family planning)? Does lack of these services constrain women from using these services?

Sexually Transmitted Infections
- ✓ Are sexually transmitted infections (STIs) a problem in the targeted community for men? For women? Are there societal attitudes that constrain the population from recognising or reporting such occurrences? Are there cultural constraints on measures to protect against the spread f STIs?
- ✓ How prevalent is HIV and AIDS among the client population? Is heterosexual transmission common?
- ✓ Is there a relationship between poverty and female sexuality that may contribute to the transmission of HIV and AIDS?
- ✓ If HIV and AIDS is a serious health problem, who cares for the AIDS sufferers? Is the care work remunerated?
- ✓ How is this work affecting other areas of work, and what are the coping mechanisms?

Family planning
- ✓ Amongst couples or extended families, who makes fertility decisions?
- ✓ Are there sex based differences in knowledge and attitudes regarding fertility decisions?
- ✓ What traditional methods, if any, do local women and men use to control fertility?
- ✓ Do women have access to contraceptives regardless of age, marital status, and number of children? Do women require the permission of males to obtain contraceptives or an abortion? What is the cost of contraceptives? How accessible are contraceptives to women and men?
- ✓ What is the family planning acceptance rate in the target population? What is the percentage of new acceptors a year? Which methods are widely accepted?
- ✓ Are there information and/or education programmes on family planning? Who offers them in the project area? Are they adapted for low literacy populations? Who do the programmes target? Men? Women? Both sexes?
- ✓ How acceptable are family planning messages to women? To men? Are the messages culturally appropriate?
- ✓ Are there "quality of care" issues associated with promotion of family planning? How do these affect women and men?
- ✓ How common is infertility? Which main groups suffer from infertility? What are the main causes and effects?
- ✓ How common is abortion? Is it legal? Which groups are primarily concerned? What are the effects on women's health?
- ✓ What are the cultural and social attitudes towards unmarried mothers? Towards children classified as 'illegitimate'?

Health delivery systems
- ✓ How effective are health services for women and men in the client population? At the primary, secondary and tertiary levels?

- ✓ What socio economic or cultural constraints do people do people face in accessing health services at each level? Are there differences in access between women and men?
- ✓ What associated health services (water supply and sanitation improvement e.t.c) do women and men in the client population have access to? To what extent to women and men actually participate in planning and managing such processes?
- ✓ Are changes being proposed in the provision of health services that will change gender relations? How will the changes affect women? Will the changes be acceptable to men?
- ✓ What formal health delivery systems are available to the client population, both clinical and non clinical? To what extent do women use them? What is the ratio of male users to female users?
- ✓ Are there women health workers in the community and what are their roles?
- ✓ Is recourse to traditional medicine and traditional healers common in the project area? Is traditional medical knowledge mainly the province of men or women? Are traditional practitioners mainly men or women? Are there female traditional birth attendants?
- ✓ What traditional health measures are practiced locally? Do health delivery systems make use of traditional knowledge? Would an inventory of traditional norms and practices assist the programme?
- ✓ What are the constraints preventing more women from being trained or being appointed as health professionals?

Fact Sheet 16: Key gender issues in HIV and AIDS

HIV and AIDS has been identified as a priority intervention area and a cross cutting issue in SADC policies, legislation, programmes and activities. It has been pointed out that 'the greatest public health and development challenge in the region'[67], and from the perspective of strategic planning, the RISDP pointed to the need for 'a radical scaling up of innovative responses at both national and regional levels'[68]. According to the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the World Health Organisation (WHO) the region had 35 percent of all people living with HIV in the world and it accounted for 32 percent of all new infections and AIDS-related deaths globally in 2007, with South Africa having the largest number of infections in the world. Swaziland's adult national HIV prevalence at 26% is the highest ever found in a country wide population based survey anywhere in the world[69].

HIV and AIDS have also had a significant impact on average life expectancy in the Region. Countries with high adult prevalence rates see correspondingly low life expectancy for both men and women. In Swaziland and Botswana, for example, the average life expectancy is a mere 32.62 years and 33.74 years respectively[70]. In addition to this, the average age of citizens of these countries are 18.5 years in Swaziland and 19.4 years in Botswana

Whilst some countries such as Zimbabwe are showing a drop in HIV prevalence amongst adults, the overall trend of a higher prevalence rate amongst adult women than men had not reversed. In South Africa, for example, it has been found that young women (15-24 year olds) face greater risks of being infected than men, accounting for 90% of new infections[71]. The risks attendant in women relative to men include unequal power relations resulting in poverty, lack of or limited power to control their sexuality, sexual assault and other forms of violence as a cause and consequence of HIV.

According to UNAIDS and UNIFEM (2004) gender based violence is now accepted as one of the "leading factors for HIV infection"[72]. SADC (2008) also points out that 'studies from Tanzania and South Africa indicate that the risk for HIV infection among women who have experienced violence may be up to three times higher than among those who have not. Research has also found that violence, or fear of violence, makes it difficult for women and girls to disclose their HIV status or to access essential AIDS services'. Few countries have policies in place, and currently no country has legislation, requiring post exposure prophylaxis (PEP) in health facilities which, once administered after a sexual assault, can reduce the likelihood of HIV and other infections.

Gender violence, HIV and AIDS

- Coercive sex can cause injuries and bleeding that can lead directly to a higher risk of HIV infection for women; typically this type of sex, including rape, takes place without the use of condoms, and women are unable to negotiate condom usage in these encounters;

[67] SADC (2003:57) Regional Indicative Strategic Development Plan.
[68] ibid.
[69] UNAIDS/WHO (2007) Sub Saharan AIDS Epidemic Update – Regional Summary.
[70] SADC Gender Unit (2007:35) Regional Progress Report on Implementation of the SADC Declaration on Gender and Development.
[71] ibid.
[72] (UNAIDS et al, 2004:47).

- Abusive relationships represent an on-going threat to women – again it is difficult for women to negotiate condom usage and safer sex practices within violent relationships;
- Research indicates that women who have been abused as children are more likely to engage in high-risk sex practices e.g. multiple partners;
- Women who know their HIV status or who are perceived to be living with HIV may be at risk of violence from partners and their community

The link between gender inequality, causes and incidence of HIV and AIDS, and its impact of the development agenda of the region, makes mainstreaming the gender dimensions of HIV and AIDS a key variable in policy, legislative and programme development at the Secretariat and Member State level. It also a key consideration in all HIV and AIDS mainstreaming efforts at all levels. Thus the 5 year Strategic Business Plan must systematically address gender equality at all operational stages; if gender equality and HIV and AIDS are not addressed in tandem, the region will fail to respond meaningfully to the challenge of addressing underdevelopment and poverty eradication.

Source: Gender Links

Checklist

- ✓ Does the Secretariat promote comprehensive periodic review of regional and national HIV and AIDS policies and SADC strategic framework to reflect and mainstream emerging gender issues?
- ✓ Does the Secretariat facilitate access to user friendly and affordable prevention technologies such as female condoms with skills-building in terms of negotiating safer sex and proper use of prevention technologies?
- ✓ What measures have been taken to enforce policies on sex education and life skills in school including special programmes for mother and girls living with HIV and AIDS?
- ✓ What programmes are there aimed at achieving meaningful involvement of people living with HIV and AIDS, especially women, in policy formulation, development, implementation and monitoring and evaluation?
- ✓ What initiatives are underway to ensure provision of affordable essential medicines for opportunistic infections and diseases such as malaria, tuberculosis and STIs?
- ✓ Are there campaigns to popularise the use of female condoms including cost reduction?
- ✓ Are there initiatives to adopt family centred and community based social transformation programmes involving faith leaders, traditional leaders, midwives and families, where cultural practices around prevention, mitigation and resolution of HIV and AIDS are openly discussed?
- ✓ How are community based social programmes to address socio-cultural and religious beliefs, norms, attitudes and practices that perpetuate the HIV and AIDS epidemic being developed?
- ✓ What initiatives have been taken to advocate for increased male involvement in all HIV and AIDS response programmes including home-based care and support services?
- ✓ Are there economic empowerment mechanisms supporting people living with HIV and AIDS?
- ✓ What programmes have been designed to develop and implement programmes and services aimed at preventing mother to child transmission and ensure that mothers and their partners have access to comprehensive anti-retroviral therapy programmes?;
- ✓ In what way is SADC promoting media training in HIV and AIDS and gender to enable the production of accurate and balanced stories, to raise awareness and disseminate information and to reduce cultural barriers, stigmatization and discrimination?;
- ✓ What messages are being developed for intensifying messages on prevention of HIV infection and the need for protection from STIs, particularly for people in long-term relationships?;
- ✓ How are treatment and counselling services being developed to address the gendered barriers in access to anti retro virals?; and
- ✓ How are stigma and discrimination of people living with HIV and AIDS being countered?