United Nations Development Programme

Botswana

GENDER EQUALITY, HEALTH AND DEVELOPMENT

POLITICAL WILL FOR HEALTH AND DEVELOPMENT: WHAT CAN PARLIAMENTARIAN DO?

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Distinguished Members of Southern African and European Parliaments! Thank you for providing me with this opportunity to present a few perspectives from the point of view of the United Nations Development Programme, UNDP.

POVERTY AND GENDER DISCRIMINATION are closely intertwined. Of the nearly 1 billion adults in the world who cannot read, two thirds are women. Girls are often the first to be pulled out of school when the family can ill afford school fees. In some countries they are also the last to be taken to the health centre when they need medical attention.

Gender mainstreaming in poverty reduction strategies is therefore critical, because poverty impacts differently on women and men, in particular when coupled with crisis and HIV/AIDS. Also critical is the need to value women's own strategies and to track how gender discrimination often widens when poverty deepens.

GENDER ANALYSES examine the ways that economic policies and budget allocations affect women as well as men, girls as well as boys, and we consequently need to set specific targets to reach MDGs that include gender equality, and

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Poverty Reduction Strategies should then set strategies to reach these goals and targets. Steps can then be taken to ensure equality in areas ranging from training and employment programmes to family policies.

The pandemic, raging like a fire in Africa and spreading fast in other regions, is no doubt among the greatest impediments to human development in the world today. The spread of HIV/AIDS is increasing among young girls and women because of their vulnerability; and because of their lack of power and means to protect themselves from unsafe sexual relations.

It therefore goes without saying that gender inequality must be central in the fight against the pandemic. Women represent a growing proportion of people living with HIV/AIDS; and in countries with high HIV prevalence, young women and girls with little or no education — those with the least power in society — are at a much higher risk than men. The 2002 Botswana HIV Surveillance Report showed that women with primary education generally had higher infection rates than their counterparts with higher education.

STUDIES IN AFRICA show that teenage girls are 5-6 times more likely to be infected by the HIV virus than boys their age. So strategies must address women's and girls' vulnerability to HIV/AIDS, as well as mitigate the socio-economic impact on women caretakers. Promoting the use of participatory methods and tools for changing gender relations and enhancing women's control of their lives is key to this.

UNDP is supporting the development of multi-sectoral poverty reduction strategies to address the economic and social impact of HIV/AIDS at the individual, community and national levels through a gender lens. It assists in developing national capacity to create and implement gender-sensitive national strategies, to translate them into the national budget, to conduct public information campaigns, and within that also the formulation of anti-discriminatory legislation.

SCOREKEEPING AND CAMPAIGNING for the Millennium Development Goals offer new entry points for gender mainstreaming. The MDGs are ambitious global targets to be achieved between 1990 and 2015. They include halving extreme poverty and hunger; achieving universal primary education; promoting gender equality; reducing child mortality by two-thirds; reducing maternal mortality by three-quarters; reversing the spread of HIV/AIDS, malaria and tubercu-

losis; ensuring environmental sustainability; and building a global partnership for development.

The relevance of gender goes well beyond the targets of achieving universal primary education and reducing maternal mortality. All MDGs have critical gender dimensions. The majority of the people who struggle to survive on less than $1 per day are women and girls. Poverty is closely associated with gender discrimination and power imbalances between men and women.

WOMEN ARE DISPROPORTIONATELY affected, as we all know by now! Both in terms of their health, and in terms of their workload, and by environmental degradation. But it is difficult to image a crisis more rooted in gender inequality than HIV/AIDS. As an MDG champion, both within the UN system and beyond, UNDP intends to utilize this opportunity to focus global attention and financial resources on the gender dimensions of human development.

Monitoring disparities between men and women, flagging gender gaps, and ensuring gender monitoring of all targets is a concrete example of gender mainstreaming. For example, recent reports have found that even when there is a decline in the overall rate of HIV/AIDS infection, the large majority of the newly infected remain illiterate young women. Similarly, when aggregate improvements in education and health are registered, they do not necessarily imply that women's access to school or reproductive health has improved.

AN ESSENTIAL FACT is that gender discrimination does not occur indiscriminately! It is mediated through a multitude of channels – like age, ethnicity, education, socio-economic status, and urban-rural location. Gender, for example, is more of a liability to a poor girl than to her non-poor counterpart; to a rural girl than to an urban one.

There is no marked difference, for instance, between girls and boys in terms of under-5 mortality. But surveys show that baby-boys face a higher risk of infant mortality than baby-girls — sometimes 50 per cent higher. After infancy, the gender gap gradually reverses. The widening gender gap is particularly pronounced for girls from poor families. In the absence of a biological explanation, environmental factors must be examined to understand the causes for this reversal. Evidence from some countries suggest that baby-boys are more likely to be vaccinated and breastfed than baby-girls — suggesting a greater commitment on the part of parents and service providers to the health and development of boys

compared with girls. In addition, you could mention an emerging trend whereby girl children drop out of school to care for sick or younger siblings after parents have died. This of course adds to the number which drops out due to pregnancy.

THEREFORE, MDG MONITORING MUST DECONSTRUCT—AND THEREBY EXPOSE—THE VARIOUS DIMENSIONS OF GENDER DISCRIMINATION.

In seriously affected countries, poverty reduction efforts need to be scaled up to counteract the deprivation-creating effect of the epidemic, notwithstanding efforts to prevent its spread and provide treatment for those infected. Poverty strategies must be 'calibrated' to meet the special needs of households and communities devastated by HIV/AIDS, improving their access to essential social services, income generation and employment programmes, and where necessary, interventions to alleviate hunger and extreme deprivation. Special attention needs to be given to poor households already vulnerable to external shocks, the needs of women, and support for orphaned children.

In countries affected by growing HIV/AIDS-related mortality among young adults, a number of key questions need to be raised as poverty reduction strategies are developed and implemented:

- DOES TARGETING OF POVERTY REDUCTION PROGRAMMES NEED TO SHIFT SO THAT THEY BENEFIT THOSE HOUSEHOLDS FALLING BELOW THE POVERTY LINE AS A RESULT OF HIV/AIDS?
- HOW CAN INCOME AND EMPLOYMENT GENERATION PROGRAMMES, CREDIT SCHEMES, AND RURAL DEVELOPMENT PROJECTS BE ADJUSTED TO THE SPECIFIC NEEDS OF HOUSEHOLDS AND COMMUNITIES IMPACTED BY HIGH ADULT MORTALITY?
- HOW CAN THE COVERAGE OF THESE PROGRAMMES BE EXPANDED GIVEN THE RESOURCE CONSTRAINT?
- WHAT POLICIES AND RESOURCES ARE REQUIRED TO ENSURE ACCESS TO BASIC SOCIAL SERVICES FOR AIDS-AFFECTED HOUSEHOLDS? AND HOW CAN THE DELIVERY OF THESE SERVICES BETTER MEET THE SPECIFIC NEEDS OF PLWHA AND AFFECTED COMMUNITIES?

OF PARTICULAR IMPORTANCE is the fact that poverty reduction strategies will need to be adjusted to respond to the special needs of women who bare the brunt of the impact of HIV/AIDS—as caretakers, breadwinners and those who are

most vulnerable to HIV infection. The unique impact on women is often poorly understood and analysed, and needs to be given special attention when poverty reduction strategies are formulated and implemented.

As women struggle to support families, earn income, produce food and care for the sick, while suffering from HIV-related illness themselves, a mix of community solidarity, support programmes and public services become absolutely essential. Special efforts are needed to ensure access to social services, land, credit, employment opportunities, markets and improved agricultural techniques.

POVERTY AND POWERLESSNESS render women vulnerable to infection. Disempowerment of women makes it more difficult for them to protect themselves from being infected by their partners, exposes them to sexual abuse and rape, limits their access to knowledge about how to protect themselves, and increases the incidence of other STDs that raise susceptibility to HIV infection. This vicious circle of gender inequality, poverty and voicelessness is at the core of the relentless spread of the epidemic.

Success in preventing HIV and expanding access to care hinges on progress in reducing income poverty and inequality, tackling gender inequality and social exclusion, and addressing lack of access to essential services—especially basic education and literacy. These conditions, and other sources of human deprivation, are important "co-factors" fuelling the epidemic because they render people vulnerable to infection and put those who are disadvantaged at high risk.

HIV/AIDS IS NOT STRICTLY SPEAKING a "disease of poverty" since it affects people at all income levels. But evidence from some countries at advanced stages of the epidemic shows that new HIV infections disproportionately affect poor people, unskilled workers and those lacking literacy skills—especially young women in each of these categories.

The relationship between poverty, gender and vulnerability to HIV/AIDS has important policy implications that require special attention in the context of both poverty reduction and HIV/AIDS programmes. Programmes aimed at empowering people politically, socially and economically in the context of poverty reduction strategies obviously contribute greatly to reducing vulnerability to HIV/AIDS. Opportunities to combine tools and methodologies to develop community responses to both HIV/AIDS and poverty must be further explored.

Many countries, not least my own country of Botswana, have definitely made progress with regard to gender equality, health and development. It is a fact that Botswana since Independence in 1966, i.e. in a relatively short timespan, has made significant strides in areas of property ownership by women, accessing land, universal education, and also in women's appointment into decision-making and influential positions. Signified by the strong position Botswana has taken in the Gender Empowerment Index of the 2003 Human Development Report from UNDP.

But there is, as always of course, room for improvement. Let me therefore mention a few areas where I believe it could be useful to focus energy.

- **Advocacy, education and consultation on the laws:** Especially marital laws. Topical issues like marital rape, exclusion of marital power in community of property, recent spate of killings directed to women and young girls as a testimony of violence against women which is still prevalent in our society.
- **Implementation of laws**: Parliamentarian should demand accountability to achieve justice by putting in place proper implementation, monitoring and evaluation of laws, which they have passed. This will enable them to identify the gaps of the laws.
- **Cultural dimensions:** Exemplified by for instance intergenerational sex. There is a need to review both common and customary laws. How do we deal with incest, defilement of both boys and girls? Which laws are more applicable and appropriate?

I have dealt more with HIV/AIDS than actually intended, and less with health in general. But I do believe that this area clearly illustrates the more general importance of empowering women and mainstreaming gender into all policies – not only policies of health, but of development in general.

Let me also say that health is an important priority in its own right, as well as a central input into economic development and poverty reduction. The importance of investing in health has been greatly underestimated, not only by analysts but also by developing country governments and the international donor community. Increased investments in health - as outlined in the WHO report called *'Macroeconomics and Health: Investing in Health for Economic Development'*, under the leadership of Jeffey Sachs – would translate into hundreds of billions of dol-

lars per year of increased income in the low-income countries. There are large social benefits to ensuring high levels of health coverage of the poor, including spillovers to wealthier members of the society.

Let me finally say – with particular reference to the HIV/AIDS pandemic - that whatever Parliamentarians might be able to do within the formal confines of Parliament, i.e. make legislation, might in fact in the final analysis be hugely less important than the example they set through their leadership and role modelling in their constituencies. Thus pushing forward the sense of 'urgency' needed regarding behavioural change.

WE KNOW A LOT! WE RESEARCH A LOT! WE MEET A LOT! WE TALK A LOT IN PLACES LIKE THIS! BUT DO ORDINARY PEOPLE OUT THERE EXPERIENCE, FEEL AND UNDERSTAND THAT WE DO MORE THAN THAT? THAT WE SUFFER AND STRUGGLE WITH THEM?

I SOMETIMES WONDER!

THANK YOU!