Health and Human Rights in Southern Africa?

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1. Introduction

This paper explores the complex linkages between health and human rights, and ways in which a human rights approach may be used to address some health issues. The intersection of health and human rights particularly in service delivery is also explored to demonstrate some of the challenges of applying a human rights approach in the health sector. The paper begins by identifying to what extent women's devaluation by society is addressed in international human rights agreements regarding violence and HIV prevention. It then moves to an analysis of the extent to which state parties in the Southern African Development Community (SADC) have developed policies that enshrine health-related rights, and specifically the recognition of gender based violence and the spread of HIV as reflecting a violation of sexual rights and requiring remedies in this area. The second part of the paper explores the extent to which a human rights approach to gender based violence and HIV prevention is being implemented through an interrogation of the values underlying health education materials produced by governments and NGOs in some Southern African countries. Finally, the paper considers to what extent mobilisation around human rights might be possible or helpful in achieving health goals.

In doing so, it focuses on five diverse countries in the region: South Africa, the newest democracy with the largest economy and population, Botswana, a long standing democracy and middle-income country and Namibia, a recent democracy only beginning to overcome substantial institutionalised inequities on the basis of race. All three are middle-income countries. Swaziland and Lesotho are both poor, and monarchies, coupled with parliamentary systems. These latter two are substantially more politically conservative and more ambivalent regarding the position of women in political, economic and public life than are the first three. The diversity of countries offers an opportunity to explore differences and similarities in the extent of a sexual rights discourse and practice.

2. Health as an international human rights issue

2.1 The right to health and health services
Member states of the United Nations are judged internationally by their recognition of and implementation of international treaties – the Declaration of Human Rights, The Convention on the Rights of the Child, the Convention on the Elimination of All Forms of Discrimination Against Women, amongst others. The United Nations system holds governments accountable, particularly once they choose to become signatories to such treaties. For this reason, an assessment of the current state of international law as well as of consensus agreements within the United Nations, is a good place to begin with, in attempting to conceptualise the parameters within which governments might be accountable for a human rights approach to health.

Access to health and health care are central tenets of international human rights treaties. The first explicit mention of a right to health is found in Article 25 of the United Nations Universal Declaration on Human Rights (1948) *"Everyone has the right to a standard of living adequate for health and well-being of himself and of his family, including food, … and medical care and necessary social services"*. Beginning with this document, a series of major international human rights instruments delineate a right to health. Article 12 of the International Covenant on Economic, Social and Cultural Rights (1966) recognises the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. The International

Convention on the Rights of the Child includes, in Article 24, the right of the child to the enjoyment of the highest attainable standard of health. These rights are extrapolated in subsequent United Nations consensus agreements. For example, the Programme of Action of the International Conference on Population and Development (ICPD) held in Cairo in 1994, requires governments to ensure access to 'basic health care' and health promotion assigning 'sufficient resources' so that 'primary health services attain full coverage of the population' (ICPD paragraph 8.4) as well as to create the environmental conditions for health, such as access to clean and safe water, waste management, addressing of air pollution and of workplace hazards (ICPD paragraph 8.10). The Platform of Action of the Fourth World Conference on Women (FWCW) held in Beijing in 1995 commits governments to *'Provide more accessible, available and affordable primary health care services of high quality…'* (FWCW paragraph 106e).

The Convention on the Elimination of All Forms of Discrimination Against Women (Cedaw) takes this further, by specifying in Article 10 that such rights apply equally to women, asserting women's equal access to *"specific educational information to help ensure the health and well-being of families"*; in Article 12 that *"States shall act to eliminate discrimination against women in health care to ensure equal access to health services"* (UNFPA 1997). These articles give health content to the overarching principle carried in all treaties of equality between the sexes and states' responsibility to eliminate discrimination against women.

In addition to the right to health, there are a range of human rights which can be applied to the health field. These include such rights as the right to information, the right to security of the person (Declaration of Human Rights Article 3), and the right not to be subject to degrading treatment (International Covenant on Civil and Political Rights Article 7). These rights are further interpreted in international consensus agreements, for example member states are required to *'Redesign health information, services and training for health workers so that they are gender-sensitive and reflect the user's perspectives with regard to interpersonal and communications skills and the user's right to privacy and confidentiality …'* (FWCW paragraph 106f); *'Ensure that all health services and workers conform to human rights and to ethical, professional and gender-sensitive standards …'* (FWCW paragraph 106g); and, in relation to adolescents, *'… ensure that the programmes and attitudes of health care providers do not restrict the access of adolescents to appropriate services and the information they need…. these services must safeguard the rights of adolescents to privacy, confidentiality, respect and informed consent …'* (ICPD paragraph 7.45).

2.2 Application of a human rights approach to sexuality and reproduction

The United Nations has given substantial attention to the interpretation of human rights in relation to reproduction and sexuality – two areas where discrimination against women has a direct impact on health. Cedaw rules that *"women are entitled to decide on the number and spacing of their children"* (Paragraph 22 of the 1992 General Recommendations on Equality in Marriage and Family Relations). This has been strengthened through the Programme of Action of the International Conference on Population and Development which defined reproductive rights as applying recognised human rights to the area of reproduction, including the right to *"decide freely and responsibly on the number, spacing and timing"* of children and *"to have the information and means to do so"*. It also asserts the right to *"make decisions concerning reproduction free of discrimination, coercion and violence"* (ICPD 1994, para7.2). The Platform for Action of the Fourth World Conference on Women (FWCW) declared that *"the human rights of women include their right to have control*

over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence" (FWCW 1995 paragraph 96) – a paragraph commonly understood as the 'sexual rights' text of the FWCW.

2.3 International commitments to gender equality in relation to HIV and violence

In addition the interpretation of human rights in relation to health, international agreements specify actions to be taken to recognise women's value, as part of the process of preventing both violence and HIV. The Platform of Action of the Fourth World Conference on Women, for example, commits governments to *'Reinforce laws, reform institutions and promote norms and practices that eliminate discrimination against women and encourage both women and men to take responsibility for their sexual and reproductive behaviour, take action to ensure the conditions necessary for women to exercise their reproductive rights and eliminate coercive laws and practices'* (FWCW 107d) and *'review existing legislation… to reflect a commitment to women's health'* (FWCW paragraph 106c). The ICPD Platform of Action commits member states to take action to promote gender equality in relation to health, *'Eliminating all practices that discriminate against women; assisting women to establish and realize their right, including those that relate to reproductive and sexual health'* (ICPD paragraph 4.4c) and *'Eliminating violence against women'* (ICPD paragraph 4.4e) in its chapter on Gender Equality, Equity and Empowerment of Women. The chapter on Reproductive Rights and Health specifies actions to address both violence and AIDS, *'In the light of the urgent need to prevent unwanted pregnancies, the rapid spread of AIDS and other sexually transmitted diseases, and the prevalence of sexual abuse and violence, governments should base national policies on a better understanding of the need for responsible human sexuality and the realities of current sexual behaviour'* (ICPD paragraph 7.38).

Remedies to which government have committed include on violence,
- 'Condemn violence against women and refrain from invoking any custom, tradition or religious consideration to avoid their obligations with respect to its elimination as set out in the declaration of the Elimination of Violence against Women' (FWCW 124a).
- '…open discussion … and educational programmes at both national and community levels' (ICPD paragraph 7.39).
- adopt measures and programmes to increase the 'knowledge and understanding of the causes, consequences and mechanisms of violence against women among those responsible for implementing .. policies, such as law enforcement officers, police personnel and judicial, medical and social workers …' (FWCW 124g).
- '… establishment of the necessary conditions and procedures to encourage victims to report violations of their rights' (ICPD paragraph 7.39).
- 'Adopt preventive measures to protect women, youth and children from any abuse – sexual abuse, exploitation, trafficking and violence, for example – including the formulation and enforcement of laws, and provide legal protection and medical and other assistance.' (FWCW 107q).

In relation to HIV and sexual and reproductive rights generally, government commitments include,
- 'Review and amend laws and combat practices, as appropriate, that may contribute to women's susceptibility to HIV infection and other sexually transmitted diseases, including enacting legislation against those socio-cultural practices that contribute to it…' (FWCW 108b).

- working with NGOs to meet adolescents' needs for education and counselling in relation to gender relations, violence, sexual and reproductive behaviour, including on contraception, sexually transmitted diseases and HIV prevention (ICPD paragraph 7.47).
- 'Give full attention to the promotion of mutually respectful and equitable gender relations and, in particular, to meeting the educational and service needs of adolescents to enable them to deal in a positive and responsible way with their sexuality' (FWCW 108k).

These agreements also promote advocacy and education for gender equality in relation to these specific health issues, for example, the ICPD Platform encourages 'Information, education and communication efforts' on such issues as 'child abuse; violence against women; male responsibility; gender equality; sexually transmitted diseases including HIV/AIDS; responsible sexual behaviour; teenage pregnancy; racism and xenophobia…' (ICPD paragraph 11.16). It spells out the role of leadership in both government, including parliaments, and civil society in promoting an understanding of these issues (ICPD paragraphs 11.17-18) as well as of use of traditional and non-traditional media, peer education and other formats for spreading information and this approach (ICPD paragraphs 11.21-24).

3. Options for action to implement a human rights approach: Recognition and redistribution

Prerequisites for the implementation of any of these rights, is an acceptance of the right to gender equality. This has two broad components, the first relates to the poor valuation of women. Underlying many of the abuses of sexual rights and reproductive rights, is the assumption made by both individual men and women, and by institutions such as health services, that women are not equal to men, that they are worth less than men, and that their needs and feelings should be of less regard than those of men. Fraser (1997:14) describes this as "cultural or symbolic injustice", a situation in which a group of people suffer non-recognition or disrespect. It is this situation which allows abuses of women, such as domestic violence, or coerced sex, to become normative in society. Since women are devalued, these injustices are not considered national priorities.

The second component of gender inequality relates to, in Fraser's terms, a socio-economic injustice (1997:13), manifest in the institutionalisation of discrimination in access to education, to employment, and to highly valued jobs within the workforce. Addressing these injustices can be done at a cosmetic level, with affirmative action, what Fraser refers to as 'surface reallocations' (1997:29). However, a social justice solution would require social transformation such that women have not only the legal right to access, but that the social conditions which limit women's options, such as their responsibility for domestic work and childcare, are redistributed between men and women, and workplace culture is reshaped to recognise both men and women's reproductive roles – in Fraser's terms, 'transformative redistribution' (ibid.).

Thus gender justice would require remedies at two levels: firstly remedies of recognition, and secondly, remedies of redistribution.

These remedies intersect with remedies required for other types of social injustice, such as discrimination on the basis of class or race or ethnicity. The right to access health care, for example, has a gendered dimension, but is not only a matter of gender. Absence of accessible health services affects men, women and children. Fees for services affect all poor people. However, given that power relations between

men and women affect women's access to household income, and that women's access to jobs is affected directly by gender inequalities, fees for services may impact differentially on men and women. In addition, women's responsibility for children means that a greater bulk of their time is spent accessing health services. Their physiology – that they produce babies – coupled with lack of reproductive rights – their ability to choose if and when to have babies – means they have greater need of health services. Thus fees for services weigh more heavily on women than men.

Failure to implement the rights to respect and dignity likewise are experienced by both men and women, but the social construction of women as promiscuous makes them more likely to suffer abuse when presenting with something like a sexually transmitted disease, whereas men may be construed as presenting with a sign of their masculinity.

This paper is an exploration of the extent to which mobilising around the concept of human rights may provide a helpful entry point for promoting health and quality health services. In doing so, we have decided not to try to explore all possible rights. In particular, we do not explore the issue of promoting equity in access to health services, since this is the predominant focus of research and debate in the field of equity and health sector reform. Such work focuses squarely on the terrain of redistribution. Rather, we have chosen to focus on questions of recognition – on that more ephemeral, hard to pin down, and invidious terrain of devaluation of women, a problem that fundamentally affects women's health and their access to health services.

We have chosen two priority issues facing Southern Africa, prevention of HIV transmission and violence against women, as the entry points for this study. While there are many intersecting causes for these problems, both are premised on women's subordination, and therefore offer the opportunity for exploring to what extent bringing a human rights – in particular a gender equality – approach to bear may improve both health status and health services.

'Sexual rights' provide an entry point to addressing the spread of HIV through sexual relationships.[1] Sexual rights as defined by the United Nations are women's *"right to have control over and decide freely and responsibly on matters related to their sexuality"* (FWCW paragraph 96). This paragraph continues by specifying the implications of this for both men and women, *"Equal relationships between women and men in matters of sexual relations and reproduction including, full respect for the integrity of the person, require mutual respect, consent and shared responsibility for sexual behaviour and its consequences"* (FWCW paragraph 96).

The definition of sexual rights has been taken further by HERA, an NGO comprising members from organisations in the north and south who lobby for a human rights approach to health. They define sexual rights as "a fundamental element of human rights. They encompass the right to experience a pleasurable sexuality, which is essential in and of itself and, at the same time, is a fundamental vehicle of communication and love between people. Sexual rights include the right to liberty and autonomy in the responsible exercise of sexuality" (HERA 1999).

There are certain prerequisites for the experience of sexual rights, all of which relate to gender equality, but to different dimensions of it. Unravelling these can best be

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[1] This paper does not consider the many human rights issues that pertain to the question of addressing HIV transmission from pregnant women to their babies. It focuses on the issue of transmission between sexual partners.

done by asking what factors lead to coercive sex and to lack of mutuality in sexual decision-making. These factors include women's economic subordination – requiring a redistributive remedy, as well as women's devaluation as human beings – requiring a remedy of revaluation or recognition.

On the economic side, women's lesser access to educational and hence employment opportunities, credit and land ownership may make them fear insisting that their husbands or sexual partners wear condoms, or refusing unsafe sex, since they rely on their partners for access to income and dare not risk losing these relationships by challenging their partners' right to sexual decision-making. Likewise, women's poorer economic position may make them resort to sex work, whether as commercial sex workers, or to having a number of ongoing sexual relationships for which they receive money or goods on which they or their children rely for survival. This situation will be further exacerbated as women householders have to cope with increased dependency ratios as breadwinners, both male and female, get sick and then die from AIDS.

Economic imperatives also impact on men in ways which undermine a sexual rights approach. The migrant labour system prevalent throughout Southern Africa, for example, has destroyed the basis of family life as it was traditionally structured in the region, that is, couples enjoying a sexual relationship within the household in which they raise children, and connected to other family members who are involved in the socialisation of children. This has led migrants, whether men or women, to seek sexual relationships outside of marriage. It has also undermined the basis of socialisation of young men and women about both sexual pleasure and responsible sexuality. However, this paper does not explore government economic policies vis-à-vis women's economic empowerment, nor economic or population policies in relation to HIV which should address head on the need to change colonial patterns of migrant labour.

Rather, it explores the second dimension of the absence of sexual rights – society's understanding of men and women's rights in relation to sexuality. On the cultural side, the devaluation of women is reflected in cultural definitions of masculinity which give men the right to make decisions about if, when and how to have sex, including whether or not to use condoms. These give men the right, and indeed recognition as 'real men' on the basis of having multiple sexual partners, while defining women who have more than one sexual partner as promiscuous. Despite this reality, women are frequently blamed by men who have a sexually transmitted disease (STD), and it is considered socially legitimate for a man to physically abuse his wife or partner on such grounds, or indeed for any reason that from his perspective undermines his masculinity. This norm is frequently described as 'custom' while many other traditional customs which sought to protect women (such as the custom that if a young man impregnated a woman he had to marry her or pay 'compensation'; or if a man beat his wife she had recourse to both his and her own family) have been comfortably set aside. Thus the prevailing valuation of men over women is reflected in the discourse as to what is and is not customary.

New 'customs' appear to be further entrenching such gender inequalities rather than challenging them. In particular, the move away from initiation schools which reinforced and socialised new generations of adolescents in social norms for behaviour between men and women, has led not to opportunities for women's greater liberation from traditional subordination, but to new cultural practices in which there is perceived to be a right to sex before marriage for men, which carries no consequences. In Zimbabwe, for example, the highest rate of new HIV infection in the country is among adolescent girls. The first sexual experience of many girls is

forced (Musasa Project, 1998). This is reinforced by a number of studies which indicate that the prevalence of sexual coercion reported among girls and adolescents mirrors the gender disparities in HIV infection in the adolescent age-groups across most countries in the region. In a report of a study of teenage mothers attending an ante-natal clinic in Cape Town, South Africa (mean age 16.3), it is stated 30% reported that their first intercourse was "forced" and 11% said they had been raped. When asked what the consequences of refusing sex would be, 75% said they would be beaten, 38% feared being laughed at and 6% felt they would lose their friends (Wood and Jewkes 1998). A study with young men in the Eastern Cape Province of South Africa showed that they believe they have the right to choose girlfriends, to have sex with them on demand and to curtail these young women's movements and choices entirely (Wood and Jewkes 2000).

Women's devaluation is also expressed in the location of sexual pleasure within the terrain of men's needs, with women's sexual needs gaining no attention. For example, the practice of 'dry sex' (Jackson 1998) which is intended to give men pleasure through the experience of a tight vagina, is not only abusive in that it causes pain to women[2], but also undermines the basic functioning of the female anatomy for sexual pleasure – the release of moisture to facilitate the penetration of and stimulation by the penis – while also substantially increasing women's vulnerability to HIV because of the abrasions it causes.

All of these factors, and the intersection between them, promote the spread of HIV, and also explain why this increase is so marked amongst younger women. These complex interrelations are perhaps best summed up by Dr Jonathan Mann in his assertion that: "The central problem of HIV in women can't be solved with posters, information campaigns or condom distribution. The central issue isn't technological or biological: it is the inferior status of women. To the extent that when women's human rights and dignity are not respected, society creates and favors their vulnerability to AIDS" (Desidamos, 1995) – revaluing women, recognising women as equals is therefore the critical human right required not only to achieve social justice, but to address critical health issues.

There is another area in which lack of sexual rights increases the spread of HIV, and that is in both the social stigma associated with, and the criminalisation of, homosexual relationships (Klugman 2000). The context of fear and secrecy associated with homosexuality in all countries in the region bar South Africa[3], makes individuals vulnerable to abuse in sexual relationships, and thereby more vulnerable to HIV. Decriminalisation of homosexuality, and, as with the poor valuation of women, a revaluation of homosexuals as equals in society, is an essential prerequisite to success in HIV prevention activities – another example where human rights need to be specifically applied to a devalued group (Fraser 1997).

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[2] That women take the steps to make their vaginas dry is evidence of the depth of their social devaluation – their acceptance that their role in life is to pleasure men irrespective of its impact on themselves emotionally or physically.

[3] While discrimination on the basis of sexual orientation is disallowed by the South African constitution, here too it will take a long time and substantial social mobilisation for this to undercut a culture of denial and abuse of gay people which remains prevalent in many social circles in South Africa.

4. Southern African policy content

4.1 Gender equality
Since a sexual rights approach is premised upon a recognition of gender inequality as discriminatory, and a desire to revalue women in general, rather than only in relation to sexuality, it is necessary to assess to what extent these countries are aware of gender inequality as an underlying cause of rapid transmission of HIV and of high rates of violence against women, thereafter considering whether they are taking any action in this regard.

SADC's Declaration on Gender and Development recognises that "gender equality is a fundamental human right" and resolves to "ensure the eradication of all gender inequalities in the region" (SADC 1999a: paragraph B.i.). It requires all member states to address gender inequality in all of their policies and activities. Furthermore, one of the critical areas of concern in the Beijing Platform for Action to which SADC governments committed themselves, is the establishment of institutional mechanisms to design, promote, monitor, advocate and mobilise support for policies to advance the status of women. National gender machineries (of varying effectiveness in promoting gender equality) have been established in all of the SADC countries.

That said, in both Lesotho and Swaziland women are legal minors which has implications both for their self-esteem and confidence to act and for such issues as inheritance, land rights, and decision-making rights generally, including in relation to sexuality and reproduction.

Botswana's constitution guarantees everyone equal protection of the law irrespective of sex. However, the dual legal system comprising Customary Law and Common Law contains provisions and practices which directly, or in effect, discriminate against women and girl children. These include the laws of marriage, inheritance and certain criminal laws (Government of Botswana 1998: 39).

The Namibian constitution makes provision for gender equality. Namibia has a gender policy and plan of action which aim to ensure that men and women have equal rights and opportunities (Department of Women Affairs 1998:1). It commits to addressing the linkages between gender inequality and health (ibid.:9).

South Africa adopted a new constitution on October 11, 1996, within which, is a Bill of Rights which guarantees equality and freedom from discrimination including on the basis of sex, gender and sexual orientation.

There is no national gender policy as yet in South Africa. However, the absence of a national policy does not appear to hinder the development of sector-specific policies which promote gender equality such as the Employment Equity Act (1999), and the Domestic Violence Act (1998) or regulations such as quotas to ensure women's participation on community water committees. The ANC government has attained the Beijing target of at least 30% representation of women in parliament, which is also a SADC target for the year 2005 (Mama 2000; SADC Gender Monitor February 1999). However, the impact of gender specific legislation is yet to be felt widely, as the administrative capacity to implement new policies is often a stumbling block.

This would suggest that some countries have a greater enabling policy environment for recognising gender inequality and taking steps to address it. While some countries have identified gender inequality through indigenous struggles, those countries which may not have expressed concern in this regard appear to be taking

on the international and SADC discourse on gender inequality. This may, however, not be the result of such influence, but rather of the growing recognition that women's subordination is a key factor influencing the high rates of HIV transmission. This is explored further in studying AIDS policies of these countries below.

4.2 HIV and AIDS
The SADC AIDS and STD Programme's *Strategic Plan* (SADC 1999b) identifies poverty as *"one of the major underlying factors in the transmission and vulnerability of HIV/AIDS/STD."* It makes the link between poverty and sexual relations, *"This has resulted in high unemployment, which has led many adults and young people [to] resort to sex work for economic survival"*. It also specifies the role of *"the weak position of women"* and *"violence"* in the rapid spread of HIV.

Its priorities for the 1999 – 2000 biennium, however, do not go into this kind of detail, referring to mobilising resources, information exchange, reducing discrimination and stigmatisation and a range of more concrete actions, but none specifying redistributive or revaluative action to promote gender equality in sexual decision-making. The closest allusion to this may be that 'cultural and policy aspects' are included in the issues that will be reviewed in a cross-country policy review process due to take place during 1999. The policy identifies commercial sex workers as a target of trans-border service provision, but does not mention those who fall into the looser non-commercial majority of women for whom transactional sex work is a survival strategy. The intended actions are to target women for HIV-related interventions rather than to consider redistributive actions that might make women less economically vulnerable in the first place; that is a symptomatic rather than preventive approach to the problem.

The SADC Health Ministers' meeting in Maputo in 1999 reoriented the SADC institutional response to HIV/AIDS, directing that its existing task force, which comprises only health sector representatives, should be broadened to include other relevant sectors (Klugman 2000). This can be taken as a sign of their increased recognition that the causes of the spread of HIV are multi-sectoral, as are the required responses.

In relation to violence against women, seven countries in the SADC region have identified the elimination of violence against women as a national priority area arising from the Beijing Platform for Action. These are Botswana, Malawi, Mauritius, Mozambique, Namibia, South Africa and Swaziland (SADC Gender Monitor, Feb. 1999). In 1998, SADC passed a resolution, 'The Prevention and Eradication of Violence Against Women and Children: an addendum to the 1997 Declaration on Gender and Development'. The addendum to this declaration signed in September 1998 recognises that *"violence against women and children reflects the unequal relations of power between women and men, resulting in domination and discrimination of women by men"*(SADC 1998). This phenomenon is acknowledged as a serious violation of fundamental human rights.

The Declaration proposes that certain measures be taken to address this issue, amongst which is *"ensuring accessible, effective and responsive police, prosecutorial, health, social welfare and other services, and establishing specialised units to redress cases of violence against women and children"*[clause17]. The declaration also proposes *"introducing and promoting gender sensitization and training of all service providers engaged in the administration of justice, such as judicial officers, prosecutors, police, prison, welfare and health officials"* [clause 19]. Most of the proposed measures require actions in the criminal justice arenas, while

the above two measures are the only specific references to health services. No reference to HIV/AIDS is made.

Lesotho's AIDS Strategic Plan lists a range of gender inequality-related issues as predisposing factors of HIV transmission, most explicitly, *'gender issues and low socio-economic status of women'* but also *'early age of sexual debut especially for many adolescent girls'*; and *'sex abuse, rape'* (Ministry of Health and Social Welfare, 1995: 9). It commits to *"support the activities of other sectors which advocate for the redress of the imbalance of the status of women vis-à-vis their male counterparts"* (Ministry of Health and Social Welfare 1995:1). However, it makes no mention of the gender inequality dimension in relation to any of the AIDS interventions it lists, from IEC and counselling programmes to institutionally based programmes for teachers, school and college students, out of school youth and specific target groups, to STD prevention programmes or condom accessibility.

In its Annex on multisectoral collaboration, the only mention of gender inequality is in the role of the Ministry of Justice and Human Rights, where *'Human rights and gender issues'* are mentioned as *'intervention areas'* with no specific activities linked to these, whereas other intervention areas for this ministry, such as advocacy, reduction of personal and social impact of HIV/AIDS, and prevention of sexual transmission, all have associated activities (Ministry of Health and Social Welfare, 1995: 26).

Swaziland's Strategic Planning Document on AIDS recognises that minority status puts women in a position where they *"cannot decide about their lives, which includes reproductive health and sexuality"* (Ministry of Health and Social Welfare 1998, section 2.3 p 8), but this has not led to policy changes on women's legal status. The document lists *'factors which are believed to be facilitating the progressively growing epidemic'*. It includes *'Unsafe sexual practices'* (Ministry of Health and Social Welfare 1998:14). Within this, it includes high prevalence of sexual activity amongst young people age between 10 and 19; high degree of unfaithfulness among sexual partners; imbalance of power in sexual relationship between males and females in favour of males; etc. In addition, it includes *'poor quality of sexual experience'*. This does not, however, appear in the list of actual 'problems' and there are not any strategies or interventions in relation to this issue.

The Strategic plan notes that *'Girls are the most affected [by HIV] due to the fact that they initiate sex earlier than boys and they also engage in sex with older men. More young girls drop out of school due to pregnancy thus losing good prospects for education and high-earning jobs.'* (Ministry of Health and Social Welfare 1998:11). It makes the link with violence noting rape and incest as a growing problem with an average of 8 cases of rape or abuse reported per month (Ministry of Health and Social Welfare 1998).

The plan identifies a range of problems to address and to each ascribes strategies, interventions and partners. However, against the problem of *'Person risk perception by married women'* and as a subsection to this, *'Low social status of women'* (Ministry of Health and Social Welfare 1998:19-20), it provides no strategies, interventions or partners. That there is no problem defined as 'Person risk perception by married men' is indicative of the failure to grasp the nature of women's subordinate status or to challenge this.

In relation to the problem of *'Wide spread casual sex practice and public knowledge and poor health seeking behaviour'*, the strategy described is *'Messages that are more focused. Review training packages on STDs for education'*; the interventions:

'Peer group behaviour change focused (beyond awareness campaign)' (Ministry of Health and Social Welfare 1998:21). Neither of these are gender specific nor is the underlying problem of gender inequality taken up in action despite that it underlies many of the problems identified in the document.

In relation to the problem identified as *'high teenage pregnancy'*, however, it does include as a strategy *'advocacy on women empowerment at all levels e.g. community leaders, partners etc.'* (Ministry of Health and Social Welfare 1998:18). Once again, however, it fails to spell this out in the explicit terms required to challenge deeply held social values regarding men and women's differential rights and roles in sexual relations.

Botswana's National Gender Programme Framework includes *'enhancing women's and men's awareness of their reproductive rights and responsibilities as well as the rights of their offspring'* (Government of Botswana 1998, paragraph 2.2.2.2 p 6), and strengthening *'a culture of shared family responsibilities'* (ibid. paragraph 2.2.2.4 p 7). It describes rape and sexual abuse as prevalent problems and a neglected area of women's health (Government of Botswana 1998). It fully recognises the interaction of poverty with violence; and that poverty is both a cause and consequence of violence, which exposes women to sexual exploitation, STDs, HIV and unplanned pregnancy (ibid:31, paragraph 5.4.1). Botswana's National Policy on HIV/AIDS recommends empowering women *"for more effective participation in decision-making about safer sex"* (AIDS/STD Unit 1993:3, paragraph 2.2, and 6, paragraph 4.4).

Botswana's Second Medium Term Plan on HIV/AIDS includes a diagram of *"determinants of HIV transmission in Botswana"* which analyses immediate determinants, underlying determinants, and basic determinants. This shows a thorough understanding of the linkages between poverty and gender inequality within culture and how the interaction of these leads to *'obligatory sex'*, *'coercive sex'*, *'sex as an exchange commodity'*, *'recreational sex'* and, linked to these last four, *'multiple sexual contacts'* which are unprotected. It also recognises that the desire for children which links to both cultural norms and poverty leaves people vulnerable to HIV (AIDS/STD Unit, 1997:15).

The Youth National Plan recognises the link between poverty and destitution, and serious social problems such as prostitution, crime, teenage pregnancy and the spread of STDs and AIDS (Republic of Botswana, 1999: 35), as well as the burden of AIDS on female girls of school going age (ibid.) and the need to protect the right of young people to education and training.

Botswana has a multi-pronged strategy for poverty reduction addressing job creation, promotion of gender equity, improving environmental management and the reduction of the AIDS infection rate. The National Plan for Youth includes diverse plans for youth economic empowerment (Republic of Botswana 1999), all addressing the redistributive dimension of sexual rights.

In general, in Botswana at a policy level, both the conceptual understanding of the problem of the relationship between poverty, the low valuation of women and HIV, and the intended frameworks for delivery are there. However, there are real barriers to implementation.

Namibia's Gender Policy and National Plan of Action on Gender identify violence against women and children as a violation of the Namibian constitution and as a fundamental threat to women's ability to enjoy *'equality, development and peace'* (Department of Women Affairs 1998:11). It identifies a range of actions government

will take, but does not make any explicit link to HIV/AIDS.[4] A Namibian informant cited violence against women as one of the country's foremost human rights problems because it affects women's ability to move freely and prevents them from exercising their rights.

Namibia's National Gender Policy and Plan of Action on Gender uses the Cairo definition of reproductive health, thus asserting men and women's right to have a *"safe and satisfying sex life, and freedom to decide for themselves when to have sex and when to bear children"* (Department of Women Affairs 1998:8). It does not go on to delineate what changes would be required in sexual power relations to put women in a position to achieve such safety, let alone sexual satisfaction.

The policy and plan spell out how discrimination against women affects their reproductive health, and particularly how *'social conditions can force girls into early marriages and pregnancies. Poverty can force them to turn to prostitution'* (Department of Women Affairs 1998:8). It then draws the links between this context and risk of unsafe abortions, unwanted pregnancies, infection with HIV/AIDS etc. Yet despite this perspective in the gender policy, Namibia's National Strategic Plan on HIV/AIDS does not identify women's lower status, nor inequality in sexual power relations between men and women as one of the causes of the problem. It does recognise *'Cultural and social issues'* as being one of the areas that the National AIDS Committee should advise on (Republic of Namibia 1998:13), but does not provide any ideas as to what these issues might be. It establishes technical advisory committees, one of which is on *'human rights and legal issues'* but again no content is given to this; and one on *'mobilisation of women, youth and workers'* but no explanation is given as to why women should be mobilised (Republic of Namibia 1998:17). Its section on Information, Education and Communication is entirely gender neutral, failing to note the need to challenge gender inequality through IEC or, at a minimum, to approach men and women in different ways (ibid: 18), as are sections on the role of the education, health services and information, broadcasting and mass media sections (ibid: Appendix D:6,11,15). The section on condom distribution likewise lacks any reference to barriers to condoms use, beyond availability (ibid: 19). On the other hand, it commits to *'ensure and support an effective male/female condom social marketing service'* (ibid: Appendix B:2) which may suggest some awareness of gender issues in relation to condom acceptability. The plan includes *'sector obligations'* and here too ignores the role of gender inequality and absence of sexual rights as a factor. The only oblique reference is in the objectives for the Youth, Sport, Culture and Entertainment sector, which include *'to develop policies to facilitate the protection of young people to enjoy their right to safe sex and planned parenthood without sexual exploitation'*; the actions, do not, specify the role of inequality between men and women in sexual relations as undermining women's right to safe sex nor are they explicit in their actions regarding exploitation – *'develop policies to protect the vulnerable groups from sexual exploitation'* – as to which groups they consider vulnerable nor what steps should be taken (Republic of Namibia 1998. Appendix D:26).

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[4] There is currently no legislation on domestic violence in Namibia, although a comprehensive proposal for the development of a Domestic Violence Act was tabled by the Law Reform and Development Commission in 1998. In addition, a Combating of Rape Act has also been tabled and is expected to be promulgated in 2000. Other policies or legislation that would have a bearing on gender violence but have not yet been passed include the Child Protection Act and the Human Rights Policy. To what extent these will make linkages between vulnerability to HIV and violence is not clear.

In 1994, the new government in South Africa adopted a National AIDS Plan which was formulated by a coalition of activist groups and the African National Congress, prior to the democratic elections of 1994. The Plan was drawn up during a time when a national Bill of Rights was being formulated and discussions around human rights in the new South Africa were at their height. Some of the key features of the National AIDS Plan were the explicit recognition of the sexual rights of women as a cross-cutting theme and to accord people living with AIDS a key role in AIDS policy development and implementation (Schneider and Stein 2000). However, the implementation of the National AIDS Plan has been slow, a characteristic of nearly all new policies. A range of more specific interventions were given priority, all within a health framework – syndromic treatment of STDs, condom distribution, and a 'beyond awareness' campaign including an AIDS Helpline. The gender characteristics of the epidemic in the rest of Sub-Saharan Africa, and the failure to address this in prevention strategies, has been replicated in South Africa despite that the initial plan embraced a human rights approach. The latest health strategic framework makes no mention of the need to address gender inequality in tackling HIV. In a separate section of the framework it focuses on women's health and here notes interventions to empower women in relation to planning of pregnancy. However, in a section on tackling violence against women and children its objectives include *"Raising awareness of the basic human rights of all, especially that of women and children through mass mobilisation strategies, the development and dissemination of IEC materials and hosting of workshops with men who are typically the perpetrators of violence against women and children"* (Department of Health 1999: 25). No mention is made of the link between violence and HIV.

These contradictions within and between policies and action indicate that at least the problem is on the agenda in the Southern African region, although there is little clarity about how to address them. This may result from the broader social context in which women's lives are not valued equally with men, and in which there is discomfort about challenging what are construed as traditional cultural mores in favour of men's control over sexual practice. Nevertheless, this brief review suggests that even countries which are not actively pursuing gender equality in their policy frameworks, such as Lesotho and Swaziland, are aware that women's lower value in society is a problem in relation to AIDS. The reality of AIDS and the recognition of women's vulnerability to AIDS appears to be putting gender inequality onto the agenda. This may be a case of a health problem helping to identify a rights problem rather than the other way around. However, with all these countries, that is as far as the recognition goes. AIDS policies tend to favour technical interventions – condom provision, treating sexually transmitted diseases – over challenging social values, although a deeper look at their AIDS education materials is required in order to assess this further.

In a region where gender violence contributes significantly to the increase in sexual transmission of HIV among women, it is imperative that the linkages between the two be explored fully. Failure to do this even at the policy level bodes poorly for the effectiveness of interventions.

4.3 Discrimination on the basis of sexual orientation

Homosexuality is a denied practice in these countries, as is lesbian sexuality. Criminalisation further limits the ability of young people, in particular, to gain information and support in relation to their sexuality. AIDS policies describe HIV transmission as resulting predominantly from heterosexual intercourse, before going on to discuss the role of blood transfusions (for example, Ministry of Health and Social Welfare, 1995: 9), and thereby leave the question of homosexuality out of the discourse and out of any consideration of risk factors for HIV transmission.

South Africa is the only country in the region where people are guaranteed equality irrespective of sexual orientation. However, the needs of homosexuals are not specifically acknowledged or targeted in AIDS prevention strategies as will be seen in the consideration of educational materials below.

5. Information and education materials

Policies of the SADC countries assessed in this paper offer little direction as regards promoting gender equality and sexual rights in particular. One key area for intervention is in changing of social mores. For this reason, this paper reviews information and educational materials produced for HIV/AIDS prevention by government and non-governmental organisations (NGOs).[5]

Outreach programmes to community groups, whether through youth or women's groups, church groups, or other structures is the main medium for preventive activities in all five countries. These are supported by radio and other media messages and in some cases by billboards. For the purpose of this review, examples of materials produced by government and by non-governmental organisations for education on HIV/AIDS has been studied, to explore to what extent these take a human rights perspective, and in particular a sexual rights perspective.

5.1 Government IEC materials
The Botswana government produced an HIV/AIDS prevention pamphlet targeting youth, 'Youth decisions in preventing HIV/AIDS' (IEC Sub-unit 1999). It identifies a range of contexts and activities which imply a lack of sexual rights for example, peer pressure; exposure to 'situations such as gang rapes'; and 'girls living in a poor family can have relationship with older men for economic reasons'. It addresses why women are particularly vulnerable, and here mentions 'the use of drying or tightening agents into the vagina in order to increase male sexual pleasure', lack of economic opportunity and hence dependence on men; the practice of men seeking sexual relations with younger women 'in the belief that this will reduce their own chances of contracting HIV'; and that young women who are beaten or threatened with violence are not in a position to negotiate for safer sex. Significantly, however, it makes no judgements on these things – no attempt to promote alternative behaviour amongst men; to promote gender equality. Elsewhere the text does promote sexual rights, with the language of, 'You have the right to say NO'; 'Do not force yourself when you feel uncomfortable in indulging in a sexual relationship'; and 'Be honest and talk openly with your partner about your needs, choices and concerns'. However, that such behaviour change means challenging entrenched inequality between men and women, and that it may have dangerous consequences for women, is not mentioned.

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[5] Information and education materials and indeed broader behaviour change programmes are often imagined as the only place in which gender inequality can be challenged. In fact this needs to be addressed across sectors, for example in health services, so that health workers understand and can respond appropriately to the gender-based issues that make it impossible for people to use condoms, to seek help with STDs or to inform their partners about STDs; in youth interventions to create recreation opportunities for both boys and girls or to provide career development opportunities directed appropriately at both sexes. A social justice approach across the board is necessary in order to begin to undo generations of gender inequality and its associated abuses of sexual rights. This paper however, only considers AIDS information and education materials, since this is the first area in which one could reasonably expect some attention to gender issues.

The IEC Manual produced by the Ministry of Health as early as 1994 (AIDS/STD Unit 1994) provides tools for developing peer education, mass media and other IEC interventions. The manual also promotes creating opportunities to explore aspects of culture which make women vulnerable to HIV, such as women having less power than men in sexual matters, and older men having younger women as sexual partners. Without being didactic, it does create the opportunity for peer groups to personalise their experience and explore the circumstances in which they find it difficult to insist on safer sexual practices. It also notes the linkage between poverty, unemployment and vulnerability to HIV, and suggests that AIDS prevention activities be linked with interventions that address these problems.

Government materials from Lesotho likewise take on the relationship between poverty and vulnerability to HIV. An IEC pamphlet, 'Women and AIDS' (Health Education Division, no date) makes a direct link between unemployment and the spread of HIV by exhorting women, 'If you can afford it help another woman who is jobless'; and 'Together with other women embark on programmes which could prevent teenage pregnancies and unemployment for girls'. It also suggests that women join organisations to 'rehabilitate other women who are involved in risky behaviour'.

Working within a more conservative cultural framework, this pamphlet engages with the cultural context, directly tackling taboos which may limit the ability to address HIV. For example, it suggests that women 'do away with shyness and overcome taboos which prevent you from educating your children. e.g. A mother cannot talk to a male child about sexual matters'. It also indicates that it is not dangerous to a baby for a woman to have sex with her husband when breastfeeding (a common traditional taboo) and mentions this in the context of saying that women should 'Keep a stable and happy married home' – thus suggesting that women must take some responsibility for their husbands' looking elsewhere for sex. They're also encouraged to let their men rather drink at home than to go out. Women are encouraged to talk to their partners about 'matters concerning sex' and to encourage them to use condoms should their partners have STDs or HIV. The pamphlet does not offer any suggestions as to how women should open such conversations without themselves being accused of infidelity or the like. Thus it does not address the underlying problem of gender inequality and may increase women's vulnerability. It does not challenge men to change their behaviour or cultural assumptions.

This limited approach is repeated in another pamphlet, 'Know the Facts, Prevent AIDS' (National AIDS Program, no date) which provides basic information on what AIDS is and how to prevent it but does not make any mention of the difficulties people may face in following its advice, such as 'stick to one faithful partner' and 'use condom when you risk casual sex'. A more personalised pamphlet for young people called 'What every person should know' (Disease Control Unit, no date) provides an explanation of the changes in young people's bodies, offering reassurance on the one hand, but proposing that young people think carefully and make decisions in advance about whether or not they want to have sexual relations and if so, to use a condom. The pamphlet does not suggest alternative sexual behaviour – it suggests kissing as 'your limit', not offering non-penetrative sexual options such as oral sex or thigh sex. A positive element is that it deals with the possibility of pregnancy as well as of contracting STDs, and, in relation to STDs, it mentions the danger of infertility as well as HIV, thus addressing a fuller range of consequences, and consequences which may be have more immediate meaning for young women and men, such as infertility than a risk of death from AIDS in the future. In general, however, while these materials may allude to sexual power relations, they do not provide the skills necessary to challenge them, and to some extent do not aim to challenge them, thus

providing the right information without addressing the underlying social causes of the problem which would enable people to act on this information.

These materials confirm that even when policy is very clear about the relationship between absence of sexual rights and HIV transmission, such as in Botswana, governments are slow to promote a sexual rights approach directly. Likewise in more conservative countries, there is a move towards challenging culture, such as taboos against women speaking with their partners about sexual practice, but within current cultural frameworks, rather than promoting equality between men and women and specifically in sexual decision-making.

A Handbook for Teachers in Swaziland produced by the Swaziland National AIDS Programme (1996) offers a specific section on Gender Roles and Their Influence on Sexuality. It describes differences in socialisation of boys and girls and then suggests that *"Parents and teachers need to consider how gender roles have contributed to social problems such as domestic violence, child abuse, … unplanned pregnancies and the spread of STDs"* (ibid. 26) but it does not provide tools for how to address this amongst students, except in one small section on helping young people deal with peer pressure to have sex. It proposes open talk in the classroom to help students realise that they have options. However, it does not recognise nor provide strategies for realising such options as *'talk to their partner about what 'I love you' means'* (ibid. 71) in the context of gender inequality which might result in women who take such initiatives being beaten up or losing their relationships. Regarding safer sex, it says that *"safer sex needs to be talked about and partners need to do this before a situation arises where sexual activity is a possibility."* (ibid. 66). The language of 'partners'; 'young people' and the like masks the reality of inequality in sexual relations between young men and young women. No suggestion is made of the need to challenge this, let alone specific activities to help young men recognise women's sexual rights, and young women to develop skills to demand such rights.

These limitations are being challenged to some extent in Namibia's extensive school-based education strategy, which involves supplying books to school libraries and running Unicef's 'Your future your choice' peer education programme. This uses youth centres, drawing on the participation of the Ministry of Youth and Sport in collaboration with Ministry of Education. These materials do promote mutuality in sexual relations, for example the section on condoms says that "It is important that girls know how to assist boys with putting on a condom. The idea is to make condom use part of the sexual play rather than a step which interrupts the sex play" (Youth Health and Development Programme 1999:25).

Material for out of school youth produced by one province in South Africa, in collaboration with NGOs, goes much further. It has a series of workshops on values, assertiveness, communicating effectively and decision-making, all of which promote individual responsibility and choice as they build skills in personal communication and negotiating. While not using the language of 'sexual rights', the manual gives a range of examples of abuses of such rights and slowly takes participants through processes to build their ability to take human rights approach (Makhanya 1999). It has a section on rape that challenges both young women and young men to rethink their behaviour and offers concrete suggestions to women about how to protect themselves particularly from date rape. It is however a little neutral on responsibility – it provides questions for discussion: *"How could Buyiswa* [the girl in the story] *have avoided being raped? Whose fault is it that she got raped: what measures could she have taken to avoid rape?"* However, there is no question asking why the boy felt free to rape Buyiswa. The fact sheet provided to teachers goes as far as saying *"If you are a man, you do not have to prove your manhood by making all the decisions and*

paying for everything. That's old fashioned and sexist" (Makhanya 95). It does not, however, say that you do not have to prove your manhood by demanding sex, let alone making any points about sexual rights of women in such a situation.

Significantly this manual does have a section on HIV/AIDS and rights, but focuses on the rights of people living with HIV, rather than on sexual rights.

The Department of Health of South Africa launched an AIDS communication campaign "Beyond Awareness Campaign", in 1997. The implementation of the campaign however, was awarded to a consortium of NGOs working in the AIDS and communications fields. One of its publications, the Beyond Awareness Manual makes mention of the growing concern around the high prevalence of rape and sexual harassment, where women are subjected to violent sexual assaults that expose them to HIV, other STDs and pregnancy. It also discusses gender as one of the issues to consider with regard to communication. The manual specifically addresses the reasons why HIV/AIDS affects men and women differently resulting in more women being infected than men. Some of those mentioned include: the prevalence of sexual abuse and rape which is perpetuated by under-resourced policing and justice systems. It further states that men are known to seek sex with virgins who are unlikely to be infected with HIV. Other issues mentioned are the economic dependence of women on men and the exchange of sexual favours for economic and other support, the association of migrant labour with increased vulnerability to HIV infection and sexual practices such as receptive anal intercourse and the use of vaginal drying agents. Gender issues are also addressed in the context of the role of the media in supporting and endorsing the social change that is necessary to cope with the AIDS epidemic in South Africa. Some of the specific issues dealt with here include women's limited access to media tools, and the perpetuation of gender stereotypes by the media

The Gauteng Department of Health in its pamphlet titled "Rape, How to Survive?" specifically address the issue of HIV/AIDS. It mentions among other things that there are drugs that you can take, that might prevent you from being infected with HIV/AIDS. It also mentions that these drugs are not free, and that they can only be obtained from private doctors. In the list of useful numbers provided in the back of the pamphlet, none are of private facilities that provide these drugs for those who may afford them. Nor is the issue of whether a medical aid would cover the costs of the drugs discussed. These are important issues as the risk of rape in South Africa and particularly Gauteng is considered to be extremely high. Furthermore, the issue of post rape prophylaxis does not seem to have gained ground after initial exposure in the media in 1999 and the government's position that there is no evidence of its effectiveness in preventing HIV infection, despite its use amongst health workers. Other advice that is given is that you can ask for the morning after pill to prevent you from falling pregnant. This is covered in the section on the police, so it is not clear whether the police provide the morning after pill.

These materials suggest that there is some space within government to promote a human rights perspective, but that this would take a lot of work in helping officials to come to terms with whatever barriers prevent them from drawing on the evidence of causes of HIV increase, which their own policies recognise – such as women's lower status and inequality in sexual relations – to put in place actions to address these. Work would be needed to understand what prevents such links from being made. Are officials simply unskilled in developing materials which promote behaviour change, or do they fear challenging cultural norms when the national leadership of both government and civil society is not speaking publicly on this issue, and thereby providing an enabling environment for doing so?

5.2 Non-governmental organisations' approach to IEC materials

NGOs tend to be on the front line of consciousness raising about human rights issues. To what extent do their information and educational materials to promote gender equality?

Some identify the problem without building skills to challenge gender inequality and promote new forms of sexual relationships. For example, a Swaziland NGO's pamphlet contains a case study that encourages a woman to leave her relationship if her boyfriend won't use a condom, but fails to suggest ways of building mutual communication and shared responsibility (TASC 1998). It has almost given up on this option, accepting that relationships cannot be changed and rather suggesting that women keep out of such relationships. A Botswana pamphlet, 'Living with AIDS in the community' (Badisang 1996), likewise suggests 'say no to sex' but goes no further.

However, moving somewhat further towards a social justice approach, a schools HIV/AIDS education guide used by a Swaziland NGO notes that talking about sex is taboo and therefore suggests the need to *"address same sexed and same aged groups so members may feel less inhibited.."* (SHAPE 72). This manual offers a section on negotiating skills. While it does not specify the differential power of young men and women in sexual relations, it does emphasize the problems of agression, *"not giving the other partner a chance to speak; losing your temper and losing control; intimidating partner into agreement"* (SHAPE 58) all of which would help to elicit discussion about sexual rights.

Most NGO materials in Botswana do assert human rights (Klugman 2000), such as "women have the right to protect their health by having safer sex" (Norr et al 1997) but few move beyond this. One which does, is an AIDS prevention training manual targeting women, developed in a partnership between WHO Collaborating Centres for Nursing Development in Primary Health care in Botswana and the USA and in close collaboration with the AIDS/STD Unit of government, which creates opportunities for groups to explore their expectations from sexual relationships and provides practice sessions on how to negotiate safer sex, in the context of asserting that 'women have the right to protect their health by having safer sex' (Norr et al 1997). Another manual for AIDS trainers (Bardsley 1995) offers opportunities for discussions of alternatives to penetrative sex, and also explores, with participants, whether adults or youth, the difficulties of talking with partners about the need for safer sexual practices (Klugman 2000).

A range of South African AIDS education materials attempt to address inequality in sexual relations. The 'AIDS in our Community' pamphlet produced by Soul City, for example, carries a 'community information' notice: *"Women do not have much power in their marriages and relationships. It is often very difficult for them to talk to their partners or to be able to say they must have safe sex. We need to fight for the rights of women"* (Soul City 11). It notes the link between violence and HIV and offers some suggestions (targeted separately to boys and girls) about how to cope with peer pressure to have sex or unsafe sex. It proposes masturbation and non-penetrative sexual activities as alternatives to unsafe sex. It discusses the need to be open and talk about sex, including at key points the issue of women's rights.

A workshop manual on AIDS prevention produced by the Women's Health Project has amongst its opening questions, *"Is it difficult for women and men to talk about AIDS? If so, why?"* (Xaba et al 2000:7) thus establishing from the start that addressing AIDS prevention means addressing dynamics between women and men.

The manual has a discussion on safer sex which is followed by an exercise exploring the gender-based reasons why it may be difficult for women in different contexts to talk about sex with their partners. It has an exercise considering *"Who does my body belong to?"* which gets participants to consider *"How is owning and controlling yourself important if you want to protect yourself from getting AIDS? Is the problem of HIV and AIDS different for women than it is for men? Why?"* (Xaba et al 2000:21) One of its primary messages is that *"Women and men have a right to take control of their bodies"* (ibid 22)

A subsequent manual produced by the Women's Health Project for the Sexual Rights Campaign is rather more explicit, given that its starting point is the promotion of sexual rights to address HIV, violence and adolescent sexual health. For example, the discussion of a role play between a girl and an older man who is pushing to have sex with her asks male participants *"think about if this were to happen to your daughters, sisters or moms, how would you feel if they were forced to do something?"*(Christofides et al 2000:13) – that way helping them to identify with women as loved ones, rather than as sexual objects. It offers case studies on HIV and on violence, in both asking participants if any rights are violated, what choices the man had and what choices the woman had in the specific context. It goes on to spell out the concept of sexual rights and to discuss how participants can protect themselves. The key messages of the workshop include that *"Women have the right to control and make decisions about their bodies; Women and men have the right to sexual pleasure; Men should not pressurise women into having sex if they don't want to; Gay men and lesbians have the right not to be discriminated against because of their sexual orientation"* (Christofides et al 2000:23-24).

In general, NGO materials, across all countries, are more likely to both note the problem of unequal sexual relations in HIV transmission and to suggest some actions. However, there is substantial diversity between them in the extent to which they promote actual revaluation of women, mutual respect and equality and shared responsibility. Some are entirely gender blind; some recognise the problem of unequal sexual power relations while others directly address these and build skills, through peer workshops, in how to challenge unequal sexual relations. Only the South African material uses an explicit 'rights' language.

5.3 Use of mass media
In some countries, NGOs have been able to conduct outreach not only through interpersonal information and educational processes, but also through mass media. However, the mass media focus on AIDS is predominantly limited to 'AIDS awareness' rather than to promoting a gender equality and a sexual rights culture. In contrast, there has been some attention, from a 'rights' perspective on violence against women. Namibia civil society groups run the Multi-Media Campaign on Violence Against Women and Children which ensures that the issue is kept on the national agenda. The Multi-Media Campaign on Violence Against Women is also engaged in lobbying AIDS organizations to make reference to violence against women. An informant described that a very powerful film that was made in Namibia to illustrate the problem of child abuse "A trust betrayed" which did not address the issue of violence and HIV. She saw this as a missed opportunity. Violence against women, especially rape and child abuse is considered to be one of the most spoken about issues, to the extent of having been included in the President's state of the nation address, and new year's speech of January 1, 2000.

In South Africa too, diverse NGOs include mobilisation of the media as one of their targets for activism. A case in point is the 1999 airing of an anti-rape public service announcement (PSA) on TV by an NGO. (Rape Crisis, Charlize Theron ad. 1999). A

group of 'concerned men' called for its banning on the grounds that it was offensive. Their call was supported by the Advertising Standards Authority, which resulted in the PSA being withdrawn. Although public protest from all quarters including the Commission on Gender Equality led to a successful appeal against the banning, the momentum gained in raising the issue of rape as a national priority was quickly eroded by the "offence" suffered by men. Although the intention of the public service announcement was to get men to recognise their individual and collective responsibility in preventing rape, it instead elicited a denial that rape is a South African male problem, nor that men should be held accountable. The Commission on Gender Equality has run a series of workshops for newspaper editors and given them guidelines in order to promote a commitment to gender equality in the media. Currently, in order to build media understanding of and ability to promote sexual rights, a range of initiatives are underway including the Media Monitoring Group working with a group of NGOs[6] to analyse the approach to sexual relations from a sexual rights perspective (incorporating both AIDS and violence issues), with the aim of producing guidelines for editors and running a workshop for editors on the findings and proposals. Likewise workshops on sexual rights are currently being run with producers at the South African Broadcasting Corporation (SABC), and talk shows on sexual rights hosting NGOs are being held by diverse public and community radio stations. Another major campaign, 'Love Life', is using billboards, taxis and other opportunities for raising consciousness about communication on sexual relations amongst young people.

5.4 Approach to sexual orientation in educational materials

In some countries, some IEC materials reference homosexual relations as one means of transmission, thus further entrenching such sexual orientation as deviant, instead of specifying which sexual *practices* promote HIV transmission, and why. For example, a pamphlet on women and HIV/AIDS from Lesotho (Health Education Division of the Department of Health no date: 6) fails to specify why anal sex can be dangerous, instead suggesting that it is homosexual relations themselves that are dangerous (Klugman 2000).

Other materials in the four countries recognise homosexuality only in so far as they associate it with anal sex; they do not attempt to acknowledge homosexuality as a common but denied human phenomenon and thereby bring a social justice approach to this issue. For example, a Botswana government pamphlet provides basic information about homosexuality in relation to safer sex, with no value judgements, although it does imply that men are 'vulnerable' to homosexuality because of resorting to commercial sex work (IEC Sub-unit 1999:13) thus presenting homosexuality as a problem.

Materials in the Namibian life skills programme acknowledge homosexuality and argue that " . . . you are born with these attractions. Gay people face different life style choices than heterosexual people and their choices should be accepted and respected." (Youth Health and Development Programme 1999:34). The Swaziland government's handbook for teachers likewise defined homosexuality and goes on to say, *"Different cultures have different views on homosexuality, but many doctors believe that homosexuality is a natural sexual preference, not behaviour which is abnormal or the result of some kind of mental illness. Homosexual couples have close and loving relationships just like heterosexual couples"* (SNAP 38). It goes on to define bisexuality as follows, *"A bisexual is someone who is sexually attracted to*

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[6] These are ADAPT, Cooperative for Research and Education, CSVR, NISAA, PPASA, People Opposing Woman Abuse, Tshwaranang and the Women's Health Project

both men and women. Bisexuality is also considered a natural sexual preference" (SNAP 38)*.* It does not, however, engage participants in discussion about this.

As mentioned above, the South African sexual rights manual also takes on discrimination on the basis of sexual orientation. It includes a case study on sexual orientation, exploring appropriate responses in this case from the person him/herself, her teacher and her mother, and asking participants to identify rights that were violated and asserting the right not to be discriminated against on the basis of sexual orientation.

To a lesser or greater extent, these materials recognise homosexual identity, in that it does not describe homosexuality as a matter of choice (Klugman 2000). They offer a positive revaluation, in Fraser's terms, of homosexuality. They suggest that despite government criminalisation and a general context of stigmatisation, those developing materials are recognising the fact of homosexuality, and making the beginnings of an effort to address the needs of homosexual people in relation to HIV transmission. This is not a full social justice approach, but at least is a sign of a door that could be pushed further open.

6. A rights approach in health services?
The main reason for looking at IEC materials is that this field seems to be further ahead when it comes to recognising gender equality as a problem in relation to AIDS, and beginning to address this issue. In the area of health services, things are even further behind, and hence have not been the focus of this paper. It is, however, worth noting some contradictions. In relation to AIDS, most countries in the region have begun by focusing on the health sector, with technical interventions for AIDS prevention – specifically condom provision and treatment for STDs. After this, some have begun to consider how to address mother to child transmission of HIV, with a country like Botswana now providing anti-retroviral therapy. Most, however, avoid taking on the determinants of effective condom usage – the ability of men and women, young and old, to communicate openly in their sexual relationships; more specifically, the ability of women to negotiate safer sex without fear of violence or loss of a relationship. In addition, they do not take on the linkages with violence, for example providing post rape HIV prophylaxis. Health services have, however, begun to take on other human rights concerns around HIV/AIDS such as confidentiality, informed consent to HIV testing and providing adequate counselling to affected persons. Protocols for the care of persons with HIV or AIDS have been in existence for a number of years in many countries. These protocols to a large extent recognise the rights of people with HIV/AIDS. The existence of a rights discourse provides some openings towards approaching other rights issues, such as sexual rights.

In the case of violence, the more 'technical' approach likewise applies, but in this case the focus has been on another sector, police and justice – what steps need to be taken when a woman reports having been violated. Here too, only recently have NGOs begun working on attitudinal issues – to ensure a supportive environment for the woman. But the preventive issues – how to change the current valuation of women such that men do not believe they have the right to abuse them; such that service providers provide empathy rather than blame for women and see it as their business to promote gender equality – are still far behind.

In relation to the health services, despite interviewing key informants in three Southern African countries, no examples of effective interventions within the health sector to build a supportive health worker response to violence against women, and to ensure effective health systems such as adequate recording of such violence,

could be found bar, again, some interventions in South Africa. Here an intervention with health workers at clinic level is currently being tested (Jacobs 1999), as is an intervention to train general practitioners to address violence appropriately. Both interventions, however, reinforce the separation of AIDS and violence, rather than offering interventions which address the underlying problem in relation to both – of incapacity of the health system to acknowledge gender relations as causing health problems. Significantly, a well evaluated intervention to address health worker responsiveness to clients, irrespective of specific health issue, Health Workers for Change (Fonn et al 2000), is not easily taken on board within the health system or by NGOs working on specific health issues, as an acceptable intervention. The approach to health issues by 'programme' (AIDS, violence, family planning etc.) rather than as integrated services persists despite policy intentions throughout the region to provide comprehensive integrated services (Klugman 1999a; Klugman and McIntyre 2000). Given the limited capacity of health systems in the region to absorb training and change processes, interventions which address underlying problems rather than attempting to take one 'issue' at a time, such as violence, or AIDS, may be more realistic while also producing a more integrated understanding amongst health workers and within health systems of the way that gender inequality impacts on a range of health issues and how it needs to be addressed across the board.

7.   Mobilisation around a human rights approach

7.1   Social barriers to recognition of AIDS
The review above indicates the limited extent to which gender equality and particularly sexual rights are being addressed in the region. Why is this? Initial research for a DFID-funded AIDS programme in these countries included interviews with diverse NGOs in each country. It identified large numbers of organisations mobilising around AIDS prevention, some working on this issue alone, others, like Red Cross, the YWCA and diverse women's groups, incorporating HIV/AIDS amongst other activities (Klugman 1999).

The continued state of denial, secrecy and stigmatisation in relation to HIV and AIDS in all these countries has shaped the approach of NGOs to the problem. The following quotes give some impression of this perception, *"People living with AIDS live in shame, hopelessness and loneliness",* Koketso Rantona, Botswana Organisation of AIDS Service Organisations; and *"Stigmatisation is the main problem. We cannot move forward unless we can get rid of it."* V.M. Khadi, Christian Health Association of Lesotho (Klugman 1999); and *"People are dying of AIDS because we are not willing to discuss sex"* Reverend Nangula Kathindi, General Secretary of the Council of Churches in Namibia (Kalondo and Rushwaya 1999:5). The problem is so severe that members of organisations of people living with AIDS describe an extremity of denial, "*People don't believe we're positive because we're not sick. People have told me that I am pretending to be sick – that the government pays me to pretend that I am HIV positive!"* Vusi Matsebula, Vice-chairperson, Swaziland AIDS Support Organisation (Klugman 1999:2). When Gugu Dlamini, an AIDS activist in South Africa was killed after revealing her HIV status during a commemoration of world AIDS day (December 1998) in Kwa Zulu Natal, the province hardest hit by AIDS, it served as testimony to both the shame associated with AIDS as well as the blame that is often directed at women who have acquired the infection. Peter Piot, the executive director of UNAIDS who was in South Africa at the time of Ms Dlamini's slaying, described her as "one of the unsung heroes of the daily struggle against HIV. Her death reminds us how stigmatizing a disease AIDS still is, and how much courage it takes for people with HIV to be open about their condition" (UNAIDS Press release, January 5, 1999)*.* This analysis points to yet another

problem of lack of recognition, to return to Fraser's conceptualisation – just as women need to be revalued, so do those living with AIDS. The denial of AIDS is the denial of the reality of an ever growing group of Southern Africans. As a result of this non-recognition, neither the causes of the problem nor adequate solutions can be developed.

Stigma makes every possible intervention difficult. Both service providers and those affected, treat AIDS not as a disease but as a matter of shame (Klugman 1999:3) and the shame seems to relate to the link between HIV transmission and sex. There is a contradiction here, since having multiple sexual relations is so publicly promoted amongst men. Yet the global discourse of confidentiality around HIV has translated in these countries into a discourse about shame. NGOs as a result are putting much of their energy, on the prevention side, into winning recognition of the reality of HIV transmission, without which further preventive activities are difficult. An AIDS organiser in Swaziland noted this obstacle by describing how *"People believe AIDS is a myth, saying 'people want us not to bear children' or 'Ah!, they don't want us to enjoy the sex act'."* Harriet Kunene, TASC (Klugman 1999:6). Thus discussion about sex gets caught up within myths about AIDS and denial about the actual problems. This is not a context conducive to promoting a positive image of sexuality and a equality approach to sexual relations.

7.2   AIDS opens the door to address diverse human rights issues

This leads to the conclusion that there are diverse human rights issues on the agenda for HIV prevention. In these countries, issues around discrimination against those with HIV are as important for prevention as they are for treatment, since an open environment which acknowledges both the reality of the scale of the HIV/AIDS epidemic, and that it results predominantly from sexual relations, is a prerequisite for effective preventive interventions. It is only once people are willing to talk about the problem, that the less visible causal issues relating to the absence of sexual rights can be raised effectively. While some NGOs, and particularly religious groups, are avoiding this approach, holding to religious and 'cultural' perspectives, or only going as far as promoting the 'ABC' approach: , 'Abstain, be faithful and condomise', AIDS-focused NGOs, women's groups and youth groups appear to be taking small steps in this direction. More skills are needed in the NGO sector, to take on this approach – how to help men, women and young people to talk about sex and to recognise the right to equality, and the value of equality from a health perspective; how to build the skills of men and women, particularly young people, to negotiate safer sex practices, and, taking this further to learn about an want to satisfy their sexual partners. Ironically, this may be a case of a health problem putting a rights issue on the agenda. Were it not for AIDS, there would be less openings to surface the impact of gender inequality and the absence of sexual rights in particular.

Another opening is provided by the inconsistencies between SADC policies on gender and on AIDS and within country policies on gender and on AIDS, with policies to address HIV not following through on apparent national commitments to gender equality. Likewise in relation to violence, where policies on violence talk about the need to challenge women's subordination in a way that violence policies do not. This reflects the differences in actors in these two fields even within governments, with health professionals being rather more conservative than those working in the general terrain of gender inequality or on violence against women (Klugman 2000). It also alerts one to the importance of non-governmental activists understanding the approach and framework of different actors, and which government departments might be mobilised to support activities to increase attention to gender equality issues in AIDS prevention, "Identifying and understanding the sources of

contradictions in policy is important for developing strategies to promote change."
(Klugman 2000).

One of the notable problems is the failure to link violence with HIV. While both
policies and materials may make passing mention of the relationship between
violence against women and vulnerability to HIV, this is not taken up in action. Watts
and Moreno (2000) suggest as a first step, that it is essential to improve collaboration
between those working to prevent HIV/AIDS and those working to prevent gender-
based violence. Groups working on violence, and those working in HIV/AIDS need to
exchange their experiences and expertise and work towards more coordinated
activities. The African Gender Institute argues for the need for 'cross-fertilization' in
both research and NGO activism (Bennet 2000).

7.3   Nature of civil society
In countries such as Lesotho and Swaziland, the predominant NGO activity is in
service provision – school life skills education, or provision of contraception – or in
addressing the impact of AIDS or violence - what one might call a 'welfarist'
approach. There are few NGOs engaged in advocacy for policy change, or in
interventions to transform government institutions and service provision. Most
notable of these are the activities of NGOS in Namibia in lobbying, organizing
demonstrations and petitions as well as in research in relation to violence against
women.[7]

It is because of the limited scope of most NGO activities, that many in the region look
to South Africa for lessons on building a human rights perspective. In South Africa,
prior to the change of government in 1994, there were a plethora of organisations
engaged in the anti-apartheid struggle with a discourse of human rights. This
extended into organisations mobilising on the health front for equity of access, as
well as for attention to specific health problems. There were also human rights
organisations and women's rights organisations. After 1994, while many were
debilitated due to a cut in the flow of donor funds to NGOs and due to the loss of
leadership into politics and the bureaucracy, some remained and became involved in
advocacy to government and at times in partnership with government to develop a
new policy approach. This accounts to some extent for the greater human rights
discourse in South African policy, despite its contradictions and limitations. At the
same time, it explains why NGOs have continued to push the boundaries, for
example in such exercises as the Sexual Rights Campaign. The major thrust of this
campaign is to change the consciousness of people in communities and build their
confidence to take action at a local level to promote sexual rights through running of
sexual rights workshops which end in commitments to local level action, while
concurrently advocating to leadership of government and civil society the need to
explicitly promote sexual rights. It is run by an alliance which includes both AIDS and
violence activists as well as groups focusing specifically on youth*[8]* (Sexual Rights
Campaign Process Committee 2000).

South Africa is held up internationally as a shining example of victory for human
rights. While its constitutional, legislative and policy changes are certainly an
extraordinary achievement after the oppression of apartheid, they are not enough. In

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[7] This paper is limited by its focus on only five countries. Other SADC countries such as
Zimbabwe have seen greater networking and advocacy around AIDS.
[8] The Sexual Rights Campaign Process Committee comprises the Joint Enrichment
Programme, National AIDS Convention of South Africa; National Association of People Living
with AIDS, National Network on Violence Against Women, PPASA, Women's Health Project
and YMCA.

the first few years after the change of government, all eyes were on policy reform. Reforms have been far reaching and very significant. However, the distance between policy and implementation is enormous, and some countries which have not had explicit human rights platforms are nevertheless further down the line in implementation, for example in the quality and scope of health service provision for AIDS in Botswana. The barriers between policy and implementation include management capacity and resource constraints as well as relational barriers – with bureaucracies failing to take on the human rights perspective of the new government (Klugman and McIntyre 2000).

7.4   Role of policy activists

There has not been substantial research on how human rights policies and practices have been won in the Southern African context. What is clear, however, is that specific actors play a key role in directing or intervening in policy processes (Gilson et al 1999; Klugman forthcoming). While conditions in South Africa created the opportunities for new policy, the development of specific policies can only be understood by analysing how civil society mobilised around some issues rather than others, and how policy activists supported this process (Klugman forthcoming) in diverse ways. Where a rights discourse and practice is on the agenda, this has been achieved through activism.

What one group of people may consider a problem differs from the next person; how a problem is understood differs too. Thus in relation to AIDS, while some may consider condom distribution the problem, others may consider premarital sex the problem, and yet others migrant labour. There are many different ways to understand and respond to a problem. There are also different policy and research institutions in any one country identifying potential solutions to problems. There are yet other institutions, particularly public sector and NGO service providers, implementing actions which may or may not resonate with those coming out of research and policy institutions. It is policy activists who can shape the way a problem is defined – for example in relation to the issues considered in this paper, it is policy activists who are identifying gender inequality and the concomitant absence of sexual rights as a core 'problem' underlying both AIDS and violence against women. It is they who need to ensure that those engaged in the world of 'solutions' take on board this approach to the problem so that the necessary research is generated, both to provide sophistication to the understanding of the problem, and to generate and evaluate interventions. This can seldom be done in an instrumental way – identifying a problem, finding and choosing amongst strategic options and then implementing and evaluating. This understanding of the process of change has been characterised as 'rationalist' and is very distant from the actual process of change which tends to involve many different and sometimes competing dynamics at any one time (Foltz 1995). It is policy activists whose task is to set up a goal and undertake diverse actions towards achieving that goal, at every point promoting the interests of the majority and those who are most marginalised or oppressed. The extent to which countries in the region take up the challenge of sexual rights will depend on the extent to which there are NGOs or other players who are able to identify sexual rights as the problem and to engage social institutions in ways which convince them of this approach.

However, such activism is also constrained by the policy environment. In those Southern African countries which are monarchies or retain women as minors, the opportunities for change are much smaller than in those which are already articulating women's subordination as a problem, and have the social institutions – educational, judicial, health and the like – to take on actions in support of a sexual rights approach.

8. A research agenda to support action for human rights

8.1   The process of change
While there is substantial research in the region on health problems, there is little research on the process of change. This is important both for understanding the scope for change and the different ways in which positive changes (in policy and implementation) have been achieved in different social contexts in the region. The field of policy research and evaluation is growing in South Africa, but more work is needed within the region as a whole. Moreover, researchers within the region need to be encouraged to undertake such work and to share its results, so that its fruits are internalised within the region. This should be an ongoing project, since policy victories may never be implemented or implementation may not be effective; gains won may be lost; and, perhaps more interesting, significant steps may be taken in implementation without the backing of formal policy.

8.2   Factors influencing behaviour change
In relation to sexual rights, while there is a growing literature on attitudes and practices, particularly amongst adolescents, not enough is known about behaviour change. Since knowledge does not lead to behaviour change, what does? To what extent are contextual factors, like the likelihood of employment after schooling, or the experience of being raised by a grandmother while parents were migrant labourers elsewhere, critical in influencing sexual behaviour of young people. Within the realm of training, what is it that makes some training only achieve an increase in information, and other training lead people to take actions at a person and social level?

8.3   Opportunities and challenges for health service interventions
While there has been some work in the region on the impact of an intervention to build health worker understanding of the impact of gender inequality on health and on use of health services (Ouma et al forthcoming) there are a range of interventions being used which require further evaluation and dissemination. Within this, research is needed as to under what circumstances public sector institutions are likely to implement evaluated interventions. This talks to the lack of an automatic link between potential solutions and their uptake in policy and implementation, discussed under 'the process of change' above.

Specifically in relation to sexual rights as they pertain to AIDS, work is needed to find ways in which health workers can support their clients in practising safer sex, specifically in negotiating with their partners for condom use and to ensure treatment for sexually transmitted diseases. Likewise in relation to sexual violence, work is needed to test protocols for addressing violence against women at clinic level; to develop a single system for adequately recording violence and identifying what steps would need to be taken to get it implemented within a health system.

Research is needed to assess whether a supportive health service can play any role in changing attitudes towards women and men's roles in society, towards a human rights perspective or whether it is a waste of resources to expect this sector to play a role in challenging overarching social attitudes.

9. Conclusion

This paper has argued that rather than a human rights approach opening the way to addressing health, a health issue – AIDS – is opening the way to put a critical human

rights issue – gender inequality and the absence of sexual rights – on the action agenda.

The remedies proposed are predominantly remedies of recognition – recognition of women as equals in society, including in sexual relations; recognition that people with HIV or AIDS are full citizens with rights and needs; recognition of homosexuals as full citizens with rights and needs.

Such recognition would provide the impetus to the provision of resources for interventions in the health sector, the educational sector, the justice and policing sectors to protect and promote gender equality. Such recognition would also give impetus to civil society organisations to move beyond welfare responses and towards a transformatory human rights agenda.

Achieving such recognition is no small task. It requires a concerted effort from policy activists working inside and outside of governments, as policy makers, service providers, as advocates, and as researchers to change national consciousness.

References

1. AIDS/STD Unit, *Botswana National Policy on HIV/AIDS,* Gaborone: Ministry of Health, 1993.

2. AIDS/STD Unit, *Information, Education and Communication for AIDS/STD Prevention, A manual for those involved in AIDS/STD Education*, NACP 23, Gaborone: Ministry of Health, 1994.

3. AIDS/STD Unit, *Botswana HIV and AIDS, Second Medium Term Plan, MTPII 1997-2002*, Gaborone: Ministry of Health, Republic of Botswana, 1997.

4. Badisang, B. Living with AIDS in the Community, MacMillan Botswana Publishing Company, Gaborone, 1996.

5. Bardsley, P., *Act on AIDS: A Manual for AIDS Trainers / Educators Using Participatory Training Methods,* AIDS Action Trust, Gaborone, 1995.

6. Bennet, J. "Gender Based Violence in South Africa," *African Gender Institute Newsletter.* Vol. 6 2000: 4-6.

7. Christofides, N., Russell, M., Conco, D., 'Sexual Rights Workshop Manual', *Health Information Workshop Manuals,* Women's Health Project, Department of Community Health, University of the Witwatersrand, Johannesburg, 2000.

8. Convention on the Elimination of All Forms of Discrimination Against Women, G.A. Res. 34/180, UN Doc. A/34/46 (1979).

9. Convention on the Rights of the Child, G.A. Res. 44/25, UN Doc. A/44/25 (1989).

10. Department of Health, *Health Sector Strategic Framework 1999 – 2004*, Department of Health, Pretoria, 1998.

11. Department of Health, *South African HIV/AIDS Materials Catalogue*, Pretoria, 1999

12. Department of Women Affairs, *Summary: National Gender Policy and National Plan of Action on Gender,* Windhoek: Republic of Namibia, 1998.

13. Disease Control Unit, *What every young person should know*, Ministry of Health and Social Welfare, Maseru, no date.

14. Foltz, A. 'The policy process'. In Janovsky, K., *Health Policy and Systems Development: An agenda for research*, World Health Organization, Geneva, 1996.

15. Fonn S, Mtonga AS, Nkoloma HC, Bantebya G, Kyomuhendo F. Asiimwe L. daSilva, Kazilimani E, Davis S, Dia R. Health providers opinions on provider-client relations: results of a multi-country study to test Health Workers for Change, a quality of care intervention. *Health Policy and Planning.* (2000, Forthcoming)

16. Fraser, N. *Justice Interruptus: Critical Reflections on the "Postsocialist" Condition*, New York, Routledge, 1997.

17. FWCW: Platform for Action of the Fourth World Conference on Women, September 1995, UN Doc. A/CONF.177/20 (October 17, 1995).

18. Gilson L, Doherty J, McIntyre D, Thomas S, Brijlal V, Bowa C & Mbatsha S (1999) *The Dynamics of Policy Change: Health Care Financing in South Africa, 1994-99.* Monograph No. 66, Johannesburg, Centre for Health Policy, University of Witwatersrand/ Cape Town, Health Economics Unit, University of Cape Town.

19. Government of Botswana, *National Gender Programme Framework*, Government of Botswana and United Nations Development Programme, Gaborone, 1998.

20. Health Education Division of the Department of Health, *Women and AIDS*, National AIDS Prevention and Control Programme, Maseru, no date.

21. HERA (Health, Empowerment, Rights and Accountability), "Sexual Rights," in *Women's Sexual and Reproductive Rights and Health: Action Sheets,* New York: HERA, 1999.

22. Hubbard, D. 2000. Personal Communication. April 20.

23. ICPD: Programme of Action of the International Conference on Population and Development, Report of the International Conference on Population and Development, 5–13 September 1994, UN Doc. A/CONF.171/13.

24. IEC sub-unit, *Youth decisions in preventing AIDS*, Gaborone: Department of Health, 1999.

25. International Covenant on Civil and Political Rights, G.A. Res. 2200 (XXI) UN Doc. A/6316 (1966).

26. International Covenant on Economic, Social and Cultural Rights United Nations, G.A. Res. 2200 (XXI), UN Doc. A/6316 (1966).

27. Jackson, H. "Societal Determinants of Women's Vulnerability to HIV Infection in Southern Africa," *Health and Human Rights* 1998, 2(4): 9–14.

28. Jacobs, T., 'Health sector response to gender violence: a model for the development, implementation and evaluation of training for health care workers', *Poverty and Inequity: The Challenges for Public Health in Southern Africa, 24-25 February 2000*, Epidemiological Society of Southern Africa, East London.

29. Kalondo, E and Rushwaya, H., "Heading the Churches: A Portrait of Nangula Kathindi," *Sister Namibia* 1999, 11(2): 4–6.

30. Keen, J.2000. Personal Communication. April 17.

31. Klugman, B, 'Annex: Social Appraisal', Initial research for Department for International Development (DFID)-funded AIDS Programme, 1999.

32. Klugman, B. Mainstreaming gender equality in health policy. *Agenda: Translating Commitment into Policy and Practice?* 1999a: 48-70.

33. Klugman, B. Sexual rights in Southern Africa: A Beijing discourse or a strategic necessity? *Health and Human Rights.* 2000; **4**(2): 132-159.

34. Klugman, B. "Empowering women through the policy process: the making of health policy in South Africa". In Presser, H and Sen G. (eds*.*) *Women's Empowerment and Demographic Processes: Moving Beyond Cairo*, Oxford University Press (Forthcoming).

35. Klugman, B and McIntyre, D, *From policy, through budgets, to implementation: Delivering quality health care services*, The Women's Budget Initiative, 2000 (Forthcoming).

36. Makhanya, N., *Sharing Tactics for Fighting HIV/ AIDS: A Guide for Peer Education*, KwaZulu Natal Department of Health; in partnership with the South African Breweries, The AIDS Foundation of South Africa and the KwaZulu Natal Youth Council, 1999.

37. Mama, A., Transformation Thwarted: Gender Based Violence in Africa's New Democracies. *African Gender Institute Newsletter*. Vol. 6 2000: 1-3.

38. Mehrotra, A. 1999. UNDP Against Violence Documents – Health: The Risks of Gender-Based Violence, http://www.undp.org/rblac/gender/genderbased.htm. April 2, 2000.

39. Ministry of Health and Social Welfare, *Strategic Plan for MTP II*, Maseru, 1995.

40. Ministry of Health and Social Welfare, *Strategic Planning Document 1998 – 2000*, The Kingdom of Swaziland National AIDS Programme / WHO, 1998.

41. Musasa Project, An Investigation into the Relationship Between Domestic Violence and Women's Vulnerability to Sexually Transmitted Infections and HIV/AIDS, Harare, 1998.

42. National AIDS Program, *Know the Facts, Prevent AIDS*, Ministry of Health and Social Welfare, Maseru, no date.

43. Norr, K , McElmurry, B and Tlou, S., *Women and HIV/AIDS Prevention Peer Education Program, A Global Approach, Training Manual*, WHO Collaborating Centres for Nursing Development in Primary HealthCare, University of Illinois at Chicago and University of Botswana, Chicago, 1997.

44. Parker, W., Dalrymple, L. and Durden, E., *Communicating Beyond AIDS Awareness*, A Manual for South Africa, Pretoria, 1998.

45. Republic of Botswana, *National Action Plan for Youth*, Draft 1999–2005 (abridged version) Gaborone: Government Printer, 1999.

46. Republic of Namibia, *The National Strategic Plan on HIV/AIDS (Medium Term Plan II) 1999–2004,* Windhoek: Republic of Namibia, 1999.

47. SADC, 'A Declaration on Gender and Development by the Southern African Development Community' in *Gender Mainstreaming at SADC: Policies, Plans and Activities,* SADC Gender Unit, Botswana, 1999a.

48. SADC*, AIDS and STD Programme, Strategic Plan, 1999–2003*, Southern African Development Community, 1999b (unpublished).

49. SADC, 'The Prevention and Eradication of Violence Against Women and Children: an addendum to the 1997 Declaration on Gender and Development' in *Gender Mainstreaming at SADC: Policies, Plans and Activities,* SADC Gender Unit, Botswana, 1999c.

50. SADC Gender Monitor, 'Monitoring Implementation of the Beijing Commitments by SADC Member States', Harare, 1999.

51. Schneider H. and Stein, J. 'Implementing AIDS Policy in Post Apartheid South Africa' *Women's Health News and Views,* 2000. No 34: 13-16.

52. Selle, R. 2000. Personal Communication. April 28.

53. Senokoanyane, D. 2000. Personal Communication. April 13.

54. Sexual Rights Campaign Process Committee, *Sexual Rights Campaign,* pamphlet, Women's Health Project, Johannesburg, 2000.

55. SHAPE, *School Health Education To Prevent STDs, HIV/AIDS Training Guide*, Schools HIV AIDS and Population Education, Manzini, Swaziland.

56. Soul City, *AIDS in Our Community*, Johannesburg: Jacana Education.

57. Swaziland National AIDS Programme, *AIDS: A Handbook for Teachers in Swaziland*, Manzini, Swaziland National AIDS Programme, 1996.

58. TASC, *Annual Report 1998,* Manzini: AIDS Information and Support Centre, 1998.

59. Universal Declaration of Human Rights United Nations, G.A. Res. 217A (III), UN Doc. A/810 (1948).

60. Vetten, L. 2000. Personal Communication. April 17.

61. Watts C., Garcia-Moreno., 'Violence Against Women: Its Importance For HIV/AIDS Prevention And Care' *Women's Health News and Views,* 2000. No. 34: 5-8.

62. Washington Ouma O, Laisser R, Mbilima M, Araoye M, Pittman P, Agyepong I, Zakari M , Fonn S, Vlassoff C. The impact of Health Workers for Change in seven settings: a useful management and health system development tool. *Health Policy and Planning.* (Forthcoming)

63. Wood, K., Jewkes, R. Love is a dangerous thing: micro-dynamics of violence in sexual relationships of young people in Umtata. *Women's Health News and Views* 1998. No. 28:24-25.

64. Wood, K. and Jewkes, R., 'Exploring young men's violence against their sexual partners in a South African township', *Poverty and Inequity: The Challenges for Public Health in Southern Africa, 24-25 February 2000*, Epidemiological Society of Southern Africa, East London.

65. Xaba, M, Moore, S. and Boikanyo, E., 'AIDS Prevention Workshop Manual', *Health Information Workshop Manuals,* Women's Health Project, Department of Community Health, University of the Witwatersrand, Johannesburg, 2000.

66. Youth Health and Development Programme, My Future Is My Choice: Participants' Work Book, Life Skills Education Training, Windhoek: Government of the Republic of Namibia and UNICEF, 1999.

Equity in health implies addressing differences in health status that are unnecessary, avoidable and unfair. In southern Africa, these typically relate to disparities across racial groups, rural/urban status, socio-economic status, gender, age and geographical region. EQUINET is primarily concerned with equity motivated interventions that seek to allocate resources preferentially to those with the worst health status (vertical equity). EQUINET seeks to understand and influence the redistribution of social and economic resources for equity oriented interventions, EQUINET also seeks to understand and inform the power and ability people (and social groups) have to make choices over health inputs and their capacity to use these choices towards health.