

DFID MSP THEMATIC BRIEF: HUMAN RIGHTS, POLICY AND LEGAL ISSUES

Background

In December 1998 a South Africa human rights violation made international headlines. A young activist, Gugu Dlamini, was stoned to death by a mob in the small township of KwaMancinza, near KwaMashu after disclosing her HIV status on national television and radio. She was accused of spreading HIV and bringing the community into disrepute. None of the community members were able to stop or report the assault and it took almost 3 weeks for the police to identify four juvenile perpetrators. After months of delays and flawed legal proceedings, in July 2001, the case was abandoned altogether.

This story demonstrated how ill-prepared South Africa was to manage HIV at both individual and civil society levels. Hence, the urgent need for interventions to assist individuals and community to address the human rights dimensions of HIV. Ten years later, South African police and human rights civil society groups have many cases reported by women, gay, lesbian and transgender who are victims of assault because of their sexual orientation, and or HIV status.

It is within this context that the implementation and monitoring of the National Strategic Plan (NSP) for HIV & AIDS and STI (2007-2011) is critical. Human rights is one of four priority areas of the NSP, which sets out issues for law reform to create a legal framework that uniformly assists HIV prevention, treatment, research and surveillance. The aim is to ensure that all individuals living in South Africa enjoy all freedoms as outlined by national, regional and international legislative and policy frameworks. These are guided by the international guidelines on HIV and AIDS and Human Rights, appendix 1.

Guided by this NSP, the Multi-sectoral HIV and AIDS Support Programme (MSP), funded by the UK Department for International Development (DFID) has contributed towards reduction of stigma and discrimination and promoting the rights of people living with HIV (PLHIV) and other vulnerable groups including women, children, and men who have sex with men.

This thematic brief

- Provides an overview of the legislative and policy environment supporting people living with HIV/AIDS in South Africa;
- Describes the MSP-funded projects that aimed to redress some of the human right violations against PLHIV through policy development, capacity building, advocacy, communication and social mobilisation and surveillance;
- Highlights the current sexual risk behaviours and some of the challenges experienced by vulnerable groups in accessing HIV health care and information; and
- Outlines the achievements of MSP-funded projects, and opportunities for sustainability towards achieving evidence-based and comprehensive sexual and reproductive health care programmes that are targeted to vulnerable groups in South Africa.

South African and International Legislative and Policy Framework

Table 1, below, tabulates the legislation and policies promoting general and specific human rights in relation to HIV - including knowledge of health status and access to health care in South Africa.

Table 1: South African and International Legislative and Policy Framework

South African Human Rights Instruments	Specific Conditions Covered relevant to this brief
The Constitution 108 of 1996	The Section 27, address the rights to health care, food, water and social security. Section 28(1) © states that children have the right to basic nutrition, shelter, basic health care services and social services.
The National Health Act of 2003	Chapter 2, Sections 6-18, highlights health rights including: ensuring that clients have full knowledge of their health status, obtaining informed consent, having access to information, protection of health records, maintaining confidentiality and procedures for clients and laying of complaints. It promotes the rights of vulnerable groups including women, children, older persons and persons with disabilities.
The White Paper on the transformation of the Health Care Systems in South Africa, 1997	The paper focuses on unified health care system that promotes equity, public-private partnerships, and integration essential primary health services.
The Patients Rights Charter-South Africa, 2002	Highlights special provisions for the special needs of vulnerable groups including infants, children,

Medical Schemes Act, 131 of 1998

pregnant women, the aged, and people with disabilities and people living with HIV/AIDS.

Promotes access and equity of medical aid benefits including those with serious illness. It prevents people from losing their benefits or from exclusion from a scheme due to pre-existing conditions for example, HIV infection status.

International Human Rights

Instruments

Universal Declaration of Human Rights, 1948

Article 25 states that an individual has a right to health care:” *everyone has the right to an adequate standard of living for the health and well-being of himself and of his family---including medical care*”.

International Covenant on Economic, Social and Cultural Rights (ESCR)

The principles promoting ESCR include the availability of health facilities, goods and programmes; quality, physical and non-discriminatory accessibility, adherence to medical ethics, providing cultural appropriate, gendered and life-cycle linked services.

Vienna Declaration and Plan of Action, July ,1993

States that human rights and fundamental freedoms are the birthright of all human beings and are universal, indivisible and interrelated.

The Declaration of Alma Alta, 1978

Highlights responsibilities of countries to provide health care to honour the right to health care

The African Charter of Human and Peoples Rights, 2003

Article 16(1) states that every individual shall have the right to enjoy the best attainable state of physical and mental health and that the state is obligated to protect the health of their people and ensure access to medical attention when sick.

Convention on the Elimination of all Forms of Discrimination against Women (CEDAW), 1997

Outlines the obligation of each country to put measures to eliminate all forms of discrimination against women.

The Convention on the Rights of the Child, 1989 and Conventions Protecting Vulnerable Groups, 1985

Outlines the right of the child to enjoyment of highest standard of health and identifies measures to ensure implementation including-reduction of infant and child mortality, malnutrition, access to education,

The UN Millennium Development Goals, 2000

preventative services and medical assistance. Other groups include refugees and asylum seeker protected by the Convention on the Rights of Non-Nationals

Four of the eight MDGS relate to health care including, reduction of infant and maternal mortality rates; reduction of HIV prevalence and reduction of TB related deaths and prevalence and burden of diseases associated with malaria.

The South African National AIDS Council (SANAC) oversees the implementation of the National Strategic Plan 2007-2011 (NSP) in South Africa. The NSP states that stigma and discrimination remain a challenge and affect HIV and AIDS management in South Africa. To address this challenge the NSP promotes human rights through the key objectives and interventions as tabulated in table 2. Progress on the implementation will be documented in a mid-term review of the NSP, planned for 2009.

Table 2: NSP Key Priority Area 4: Human Rights and Access to Justice

Objectives	Proposed Intervention
Ensure adherence to existing legislation and policy relating to HIV and AIDS(employment and education)	<ul style="list-style-type: none"> • Conducting a gender analysis of existing workplace programmes • Developing HIV and AIDS workplace policies, programmes and M&E • Developing guidelines of rights and HIV and AIDS of children in schools
Ensure adherence to human rights by service providers	<ul style="list-style-type: none"> • Development of guidelines on HIV testing, including testing of children
Ensuring supportive legal environment for the provision of HIV and AIDS services to marginalised groups	<ul style="list-style-type: none"> • Development of information, communication, educational materials for vulnerable groups including: drug-users; sex workers, children, older persons, prisoners, refugees and gay, lesbian and men who have sex with men.
Monitor and address sexual violation	<ul style="list-style-type: none"> • Develop M&E tools and systems
Improve affordability and accessibility of legal services for people with HIV	<ul style="list-style-type: none"> • Training of legal professional and community development workers on human rights and HIV and AIDS and to identify and address

Empower PLHIV to recognise and deal with human rights violations

Ensure respect for the rights of PLHIV in employment, housing, education, insurance and financial services and other sectors

Promote greater openness and public acceptance of PLHIV

- Implementing interventions and monitoring of protection of human rights and unfair exclusion to financial or insurance services
- Developing a database of and creation of network of legal service providers to assist people with HIV and AIDS
- Development of human rights manual for PLHIV and conduct training with PLHIV and organisations providing services to PLHIV
- Ensure integrations of human rights into all media campaign
- Development of policies and programmes on human rights of PLHIV across government sectors and SANAC structures
- Launching of sectoral and community-based campaigns promoting and protecting human rights
- Building capacity and provide information on the promotion and protection of human rights in all sectors (including public, private and civil society)

MSP-funded Projects

The National Department of Health's Maternal Child and Women's Health and Nutrition cluster (MCWH&N) in partnership with DFID, through the MSP, has implemented several projects to address some of the objectives on human rights and access to justice. Table 3, summarises these projects by theme.

Table 3: Summary of Projects

Theme	Project	Service Provider	Partner	Timeframe
Policy Development	Development of National Policy & Guidelines for Fertility options	MIS Design	National Department of Health (MCHWH&N)	February 2007- November 2008
Capacity Building	Curriculum Development and Training Manuals for Sexual Assault	Gender and Health Research Unit, Medical Research Council	National Department of Health (MCHWH&N)	February 2007- November 2008
	Siyayinqoba Beat It- Community Journalist Project	Community Health Media Trust (CHMT)		October 2007- November 2008
	Treatment and Prevention Literacy and Training to strengthen the Public Health Systems and Promote Health seeking behaviour at a population level	Treatment Action Campaign(TAC), HIV-iBase & CHMT	Eastern Cape Department of Health	October 2007- November 2008
	Expanding Treatment Literacy and improving HIV knowledge: Eastern Cape	Treatment Action Campaign	Eastern Cape Department of Health	October 2006- November 2008
Advocacy, Communication and Social Mobilisation	One Man Can- Campaign in KwaZulu-Natal, Limpopo and the Eastern Cape	Sonke Gender Justice	National Department of Health (MCHWH&N)	September 2007- December 2008
Surveillance	Understanding Men's Health and Use of	Gender and Health Research	National Department of	June 2007- October 2008
	Violence-Interface of rape and HIV in South Africa	Unit, Medical Research Council	Health (MCHWH&N)	
	The Johannesburg and eThekweni Men's Study: A rapid assessment of the HIV Epidemic among Men who have Sex with Men in South Africa	Human Resource Council & Centre for Health Policy at WITS University	National Department of Health (MCHWH&N)	February 2007- November 2008

Policy: The development of National Policy & Guidelines for Fertility Options for South Africa

In 2007 the antenatal HIV prevalence rate was estimated at 28%. The provinces of KwaZulu-Natal, Free State, Mpumalanga, and Gauteng were the worst-affected, with HIV prevalence rates of 37.4%; 33.5%; 32%; 30.3% respectively¹. The antenatal survey stated that the worst affected are women aged 20-40 years, reaching a peak of 40.2% in the 30-34 year age group. Prevalence in the 25-29 year age group was estimated to be 37.9%.

The antenatal survey also estimated that there about 2.8 million women and 2.3 million men living with HIV in South Africa. The number of children living with HIV who are younger than 14 years of age is estimated to be 184,680. Generally, HIV/AIDS infection has been shown to reduce fertility levels. There is international and national evidence showing that HIV-positive women are 25-40% less fertile than their negative counterparts.

The process of developing a policy on fertility options involved a review of a number of reproductive health policies in South Africa. These included the Choice of Termination of Pregnancy, the National Contraception policy, the Sexual Assault protocols, the National Maternity Care guidelines, the National Cervical Cancer Screening guidelines, the Comprehensive HIV prevention, treatment and care plan, Prevention of Mother-to-Child HIV Transmission (PMTCT) guidelines and the National Committee for Confidential Enquiries into Maternal Death guidelines.

A desk-top review identified gaps in the implementation of the above mentioned policies across provinces. The review highlighted many challenges and complexities such as high prevalence of HIV and AIDS, gender based violence, variations between districts and provinces and limited access to appropriate and relevant services. It was critical that the new policy took these into account in order to ensure an inclusive approach to developing the fertility option policy.

The fertility option policy, therefore sought to create linkages to ensure that there is integration of sexual and reproductive health and HIV and AIDS prevention, treatment and care thus contributing towards achieving the Millennium Development Goals (MDGs) by 2015.

This project aimed to develop a national policy, guidelines, and M&E framework on fertility options for men and women in South Africa. The process involved promoting an enabling environment for

¹ National Department of Health, *The National HIV and Syphilis Prevalence Survey*, NDOH, South Africa, 2008.

understanding fertility challenges experienced by HIV-positive women, men and the youth. The objectives were to improve and increase access to affordable, accessible and safe fertility services for men and women of reproductive age. Numerous provincial consultative workshops were held with experts from public and private sectors and civil society organisations to identify current evidence, identify challenges and to begin to outline the framework implementers and specific, measurable, relevant and time-bound indicators (SMART).

By the end of the project, a policy that fosters integration with existing reproductive health policies, was developed with 6 objectives linked to their strategies and M&E indicators. An implementation plan was also developed that outlines the activities, time frame and actions to be taken by MCWH&N cluster to ensure implementation of this policy and guidelines. The policy themes include options for men, women, youth, minority groups, people with disabilities, HIV positive persons. It also calls for the participation of non-traditional carers including traditional healers, traditional birth control workers, and alternative reproduction carers to provide comprehensive fertility care services.

The lessons learned from this project were that, it is important to:

- Conduct a situational analysis of current reproductive health status and service delivery in the provinces in order to inform strategies for the implementation of the policy;
- Ensure that the policy is inclusive and addresses the needs of various groups that are likely to be affected including: HIV positive women, men and youth and those with medical conditions and other minority groups;
- Avoid exclusion or neglect of sexual and reproductive health care needs of HIV-positive women;
- Ensure that linkages between the reproductive health policies are made; and
- Involve public health sector implementers so that corrective measures are immediately implemented.

Capacity Building: Curriculum and Training Manuals Development for Sexual Assault Care Practitioners in South Africa.

According to the South African Demographic and Health Survey (SADHS) of 1998, women in the age group (15-24), reported the highest incidence of abuse by a partner in the last year (7.3% for age group 15-19; 7.9% for age group 20-24). With a high HIV prevalence rate in South Africa, HIV infection through rape is a great concern and management of rape survivors is therefore critical. In

addition rape survivors are likely to develop post-traumatic stress disorders and other mental and physical health problems including pregnancy and sexually transmitted infections. To achieve availability and access to comprehensive sexual assault care services (including Post Exposure Prophylaxis (PEP) and psycho-social support), the Maternal and Child Women's Health and Nutrition (MCWH&N) cluster together with the Gender and Health Research Unit at the Medical Research Council (MRC) developed the training curriculum and facilitation manuals for care practitioners.

The aim of this project was to develop evidence-based, in-service, post-care training materials. The training materials offer comprehensive response to management of rape survivors by integrating physical, psycho-social, medical management; by developing skills rather than knowledge among practitioners to manage survivors; by addressing social context and sexual rights and by meeting the needs of children and men.

The process of material development included three stakeholder consultations. The first consultation focused on identification of 28 local experts and a review of both local and international training curriculum materials by 12 of these experts. The second consultation focused on piloting the proposed training curriculum to all provinces, including four provincial meetings and the last focused on evaluation of the post-rape care training.

The project outputs included a Training Curriculum that consists of 5 modules. Module 1: focuses on social context of rape in South Africa; Module 2: addresses an initial approach to rape survivors (communication skills and taking history and obtaining consent); Module 3: outlines the management of health and mental problems; Module 4: outlines steps on conducting an examination (medical-legal, forensic, children) and documentation of evidence and Module 5: outlines the steps on what a carer should do after the initial consultation (following up and managing vicious trauma). In addition, the Facilitator Manual was developed to provide guidelines on how to prepare for and conduct training and on how to manage facilitation and group dynamics. Furthermore, a training DVD was produced and a survivor guide to be used by clients accessing services was also developed.

The evaluation of training findings showed that there was a change in management knowledge of post-rape care among practitioners with a mean score rising from 27 at pre-training to 35 at post-training ($p > 0.0001$). There were attitude changes between pre and post-training ($p = 0.0002$) and overall the level of confidence in all aspects of post-rape care increased. The MCWH&N printed all training materials and facilitator manuals and has integrated this training in their annual operational plans to ensure that training is cascaded to all facilities. The developers have further trained

approximately 40 nurses and doctors and had facilitated training of health professionals from 7 countries in Southern African Development Community (SADC) region. There are also plans to conduct training in Zimbabwe, Kenya and Malawi in the near future.

Capacity Building: The Treatment Literacy Project

Treatment education prepares people for treatment and engages communities and individuals to learn about antiretroviral therapy so they understand the full range of issues involved with treatment. It facilitates an understanding of the benefits of treatment, the importance of maintaining protective behaviours, knowing one's HIV status, getting access to treatment, adhering and supporting others to adhere to treatment and understanding the negative role of stigma and discrimination and gender inequality. Complementing the provision of drugs and medical care, treatment education prepares and involves people in comprehensive responses to HIV and AIDS, and places people on treatment at the centre of their own choice².

The Treatment Literacy Project, funded through the MSP, consisted of three components: 1) Prevention Messaging; 2) Prevention and Treatment Messaging and 3) the Treatment Literacy Information. The first component focused on producing public service announcements, while the second component produced the communication campaign and the third and last component focused on producing training materials. A treatment literacy series in Sesotho was developed and training for the Community Journalists was conducted.

Challenges highlighted by these projects include:

- Lack of prevention messaging that focuses on drivers of epidemic and behaviour change;
- Limited evidence on the impact of HIV and AIDS on the health system;
- Stigma and discrimination against people living with HIV; and
- Uncoordinated messaging on HIV prevention and treatment.

The project aimed to raise awareness about HIV prevention and treatment and improve media coverage of the HIV/AIDS epidemic. The purpose was to develop integrated and unified messaging, using different media the quality and scope that are accessible to many communities in South Africa.

By the end of the project, seven public service announcements were developed in three languages. These messages were also integrated into an edutainment show. Stand-alone health messages, as

² UNAIDS, *Inter-Agency Task Team-Treatment Education*, 2006

well as adverts were developed for print media, and radio and television broadcast. Training materials and a treatment Literacy Series in Sesotho were developed. During their training the community journalists produced 78 quality documentary inserts for SABC, with topics including herpes and sexual networks, gender based violence, PMTCT, workplace rights, HIV status disclosure, hate crimes, regular testing, teen pregnancy and aspects of the NSP.

The lesson learned from this campaign was that using a comprehensive, multi-pronged and unified messaging approach works. As a result, the viewer ship increased from 1.6 million people on the first series to 3.4 million people on the last series. The broadcast have brought greater depth and authenticity of the impact of HIV and AIDS, drawing communities and youth viewer ship.

Advocacy, Communication and Social Mobilisation: One Man Can (OMC) Campaign in KwaZulu-Natal, Limpopo and the Eastern Cape

Working with men and boys to reduce the spread and impact of HIV/AIDS, the OMC was developed and launched in 2006. It was informed by a number of studies conducted in South Africa, among which is a study conducted among 1370 male volunteers from 70 rural areas of South Africa that reported that 16.3% of men had raped a non-partner and 8.4% had been sexually violent towards intimate partners (Jewkes, 2006³). Almost one third (31%) of sexually active women reported that their first sexual encounter was coerced (Kalichman, 2007⁴). It was also reported that only 56% of clinic or hospital staff have been trained to care for gender violence survivors and that post exposure prophylaxis available to only 15% of public sector clinics.

This is a huge challenge for South Africa, as it has both high numbers of people living with HIV in Southern Africa and very high levels of gender based violence. Funded by DFID, One Man Campaign (OMC) implemented by the Sonke Gender Justice, uses evidence-based strategies to promote gender transformation including training, technical assistance for government and civil society organisations. OMC assists men to advocate for gender equality, including taking a stand against domestic and sexual violence, changing gender norms and promoting and sustaining change to protect themselves and partners against HIV and AIDS.

The key objectives of the project were to:

³ Jewkes R, Dunkle K, Nduna M, Levin J, Jama N, Khuzwayo N, Koss M, Sikweyiya Y (2006). Rape perpetration by young rural South African men: prevalence and risk factors. *Social Science & Medicine* 61,1809-1820.

⁴ Kalichman, C., Simbayi, L.C., Cain, D., Cherry, C., Henda, N. & Cloete, A (2007). Sexual assault, sexual risks and gender attitudes among South African men. *AIDS Care*, 19(1), 20-27.

- Conduct formative research to inform the OMC, focusing on knowledge, attitudes and practices of men on HIV and gender based violence and on increasing understanding and awareness to end men's violence;
- Conduct capacity building training over 12 months with CSOs to implement the OMC approach in their programmes and promote the establishment of community action teams;
- Implement communication strategies to shift social norms about men's roles and responsibilities including the use of digital stories and photo voice methods;
- Engage in advocacy to implement legislation and policies relating to gender based violence and male involvement;
- Collaborate with local government to develop and implement policies and strategies aimed at increasing men's involvement in achieving gender equality; and
- Conduct monitoring and evaluation and dissemination of findings.

By the end of the project, the following resources had been developed:

- a One Man Can Campaign Toolkit, including a workshop manual for men with the aim of raising awareness and addressing these issues;
- stickers to increase visibility of the issues;
- a CD featuring music about ending violence and addressing HIV and AIDS;
- video-clips of men taking action at local level; and
- posters and fact sheets on gender, shifting social norms about men's role and responsibilities, violence and HIV and AIDS.

The One Man Can-Community mobilisation model involved conducting workshops through community networks, events or peer education. Each workshop targeted up to 30 people at a time and was conducted over 4-5 days using interactive and experiential activities. The workshop manuals are available in 5 South African languages and can be downloaded from the Sonke Gender Justice website (www.genderjustice.org.za). There were also pre- and post-evaluations conducted around the workshops.

The project reached approximately 4500 men between ages 15-40 years in all three provinces. A follow-up telephonic survey was conducted with 181 men and women that attended the workshop to identify behaviour changes. Around one quarter reported to have undergone HIV testing, just over half (51%) reported that they had notified policies on gender based violence and over a third (35%) had reported it to civil society organisations. Nearly two-thirds (61%) reported to have used a condom during sexual intercourse.

In terms of sustainability, the OMC is now implemented in 8 of the 9 provinces of South Africa and in the region including Namibia, Botswana, Zambia, Lesotho, Rwanda, Burundi, Mozambique, Kenya and Uganda. The OMC kits are used by various stakeholders including sport coaches, teachers, taverners, ward councillors and correctional services staff. Furthermore the materials are used to expand the scope of male involvement in other social activities including caring for orphans and vulnerable children and other behavioural change activities including reduction of multiple sexual partners, and with other vulnerable groups including refugees and asylum seekers, migrants and farm workers.

Moreover, some of the local and international civil society organisations are implementing the OMC and reprinting materials to distribute within their catchments areas.

Surveillance: Understanding Men's Health and Use of Violence - interface of rape and HIV in South Africa

Violence against women is the major contributor to ill-health, including HIV infection, and is a public health and human right problem worldwide. In 2008, 54,920 rape cases were reported to the South African police and a quarter (25%) of women, in the general population had experienced violence, rising to over 40% in targeted studies. Jewkes' 2006³ study reports that women who experience violence have more risky sexual practices and men who have raped and are physically violent have more risky sex practices. Another study found that pregnant women who have experienced violence are 54% time more likely to have HIV (Dunkley, 2004⁵).

A cross-sectional study, funded by DFID, was conducted in two provinces (KZN and Eastern Cape) with the aim of describing the prevalence of rape among men between 18-49 years in the general population and describing the association between rape, intimate partners and HIV. Two hundred and fifteen enumeration areas were researched, and about 1,738 men were interviewed using an audio-enhanced palm-top computer (personal digital assistant). In each province, three districts were targeted - rural, urban and city.

The study found that over a quarter (27.7%) of men reported to have ever raped a woman or a girl. Forty six (46%) percentage reported to have raped more than once, 14.3% have raped a current or ex-girlfriend or wife, 2.9% reported to have raped a man or a boy. Nearly a tenth (9.6%) of men

⁵ Dunkle KL, Jewkes R, Nduna M, Levin J, Jama N, Khuzwayo N, Koss M, Duvvury N. (2006). Connections between perpetration of partner violence and HIV risk behaviour among young men in the rural Eastern Cape province of South Africa. AIDS. 2006 Oct 24; 20(16):2107-2114.

disclosed that they had been forced to have sex with another man and this group was 2.26 times more likely to report having raped a woman. Factors associated with HIV included: ever having had intimate partner violence; being 25 years or older; having matric or tertiary education; having had a genital ulcer; being circumcised; having occasional work; lacking parental presence or guidance; a reported a history of being bullied, harassed or teased; and having been involved in criminal behaviour.

Of the 42.4% of men who reported having ever been violent more than once with intimate partners, 39% were infected with HIV ($p=0.0004$). The 30-34 age group category that had ever been violence with an intimate partner more than once, had the highest HIV prevalence rate of 45%. After age 35 years, the HIV prevalence rate decreased and after 45 years it was higher among men who had never been violent with an intimate partner. The factors associated with intimate partner violence and sexual risk taking include: having transactional sex; having 20 or more sexual partners; having ever raped a women; high levels of alcohol consumption in the past year; and sex with a prostitute. The study also found that men who raped did not have a significantly higher HIV prevalence than men who hadn't raped (19.6% vs. 18.1%); however, there was a significant difference among men who had raped men (26.7%).

The researchers concluded that ideas about masculinity and sexual entitlement were main key predictors of gender-based sexual assault. Considering that the prevalence of rape is generally high in South Africa, broad-based rape interventions are necessary to address the drivers of intimate partner violence. The project provided in-depth knowledge about the connections between rape, violence and HIV. It also outlines the high risk of HIV among rape survivors and the need for early reporting and access to prophylaxis (PEP). In addition, it highlighted the psychological impact and vicious cycle of rape on both men and women, hence, advocating for post-rape interventions that are comprehensive and inclusive. In June 2009, a policy brief written by the principal investigator was produced and the study findings were released in national and international media. Subsequently, there have been innumerable international press stories about the study.

Surveillance: The Johannesburg and eThekweni Men's Study: A rapid assessment of the HIV Epidemic among Men who have Sex with Men in South Africa

HIV incidence and prevalence information among men who have sex with men (MSM) in South Africa is limited. Recently, studies have been conducted to determine HIV testing practices among MSM in Durban, Cape Town and Gauteng between 2003 and 2005. It was found that 14.1% of participants who had been tested for HIV were positive, that the majority of HIV-positive MSM

experience stigma and discrimination and that there was a high incidence of unprotected anal intercourse, in particular among those who reported high alcohol consumption^{6, 7, 8}.

Hence the rationale for this study, conducted between October 2007 and November 2008, in two metros (Johannesburg and Durban) by the Human Sciences Research Council, the Centre for Health Policy, the University of Witwatersrand School of Public Health and the Medical Research Council, was to provide information on HIV prevalence among MSM, identify risk behaviour and the social contexts in which HIV transmission occurs, and understand better the need for specialised HIV the programmes and services for MSM.

The overall objectives of the study were to: 1) audit current HIV prevention, treatment and care services as well as HIV testing and counselling services for MSM in Johannesburg and eThekweni metros; 2) determine the HIV prevalence amongst MSM; 3) describe sexual and other risk behaviour for HIV infection; 4) describe access to HIV-related health and social services; and make recommendations on developing interventions targeting MSM. The study used both qualitative and quantitative components, including key informant interviews, focus group discussion and a survey among 282 men (201 in Johannesburg, 81 in Durban). Participants were given an opportunity for unlinked anonymous HIV testing. Pre- and post-test counselling was conducted by staff from the Society of Family Health.

The study's descriptive findings were that a third of participants were 25 years and younger, 88% were black (African), 53.6% had Grade 12 or more education, 78.9% were self-identified as having gay or homosexual orientation and 35.5% were employed. In addition, the study found the HIV adjusted prevalence rate to be 38.3% (N=116), with nearly two-thirds (65.2%) amongst men older than 25 years. Fifty-seven percent of participant had undergone HIV testing and just over a third (36.9%) had knowledge on HIV prevention. Almost all (97.9%) knew where to access HIV testing services. Of those that were HIV positive, 94% reported to have had receptive anal sex and 67.2% reported to have had sex with someone 10 years older than themselves. Some of the high risks behaviours reported included unprotected anal sex, alcohol consumption, and transactional sex, use of lubrication and drug use. There were reported misconceptions about risks and there were

⁶ Cloete A, Simbayi LC, Kalichman SC. Disclosure decisions and HIV positive men who have sex with men (MSM) in Cape Town, South Africa. Paper presented at the XVII International Conference on AIDS. Mexico City, Mexico, 2008.

⁷ Sandfort TGM, Nel J, Rich E, et al. HIV testing and self reported HIV status in South African men who have sex with men: results from a community based survey. *Sexually Transmitted Infection* 2008;84: 425-429.

⁸ Lane T, Shade SB, McIntyre J, Morin SF. Alcohol and sexual risk behaviour among men who have sex with men in South African township communities. *AIDS & Behaviour* 2008; 12(4 Suppl):S78-85.

reports of limited access to information, education and communication (IEC) materials on HIV transmission, testing, treatment and care outside those distributed by the Lesbian, Gay and Transgender organisations. Stigma and judgemental attitude were reported to be barriers to accessing mainstream HIV –related services.

The study was the first large-scale study among MSM, using a respondent-driven sampling method in South Africa. It provided information on HIV prevalence and risk behaviour among MSM, contributing towards closing the information gaps for M&E identified in the South African NSP. However further and ongoing surveillance is required. Through this study, some of the indicators required for the submission of UNGASS report were provided and important lessons on recruiting MSM and for HIV and behavioural surveillance were documented.

Conclusion

The MSP projects supported by over £35 million DFID funding have supported the development of a policy framework and training materials, the development of baseline indicators on vulnerable groups and the implementation of innovative interventions. These initiatives have closed some of the gaps and have contributed towards achieving some of the objectives in the NSP on human rights and access to justice.

The MCHWH&N cluster at the National Department Health remains committed to ensuring that the training on post-rape care of health professionals is cascaded to all facilities in South Africa. The policy on fertility options implementation plan is underway and the research results of the projects presented have been distributed widely, including presentations at the 4th South African AIDS Conference held in March 2009. In addition, the information gathered by the research has also informed practice and targeted programme development.

Overall, the MSP-funded projects have made a valuable contribution to the efforts, as outlined in the NSP, to bring about an enabling environment in South Africa that promotes and encourages respect for human rights by ensuring that the human rights is mainstreamed into HIV prevention, treatment, care and support. These projects have managed to develop and promote policy-oriented research, build capacity of individuals, communities and health professionals and disseminate knowledge on human rights and HIV using various media and strengthen public-private partnerships and transference of skills by working together a strategy supported by the NSP.

Appendix 1:

International Guidelines on HIV/AIDS and Human Rights : 2006 Consolidated Version Organized jointly by the Office of the United Nations High Commissioner for Human Rights and the Joint United Nations Programme on HIV/AIDS

GUIDELINE 1: States should establish an effective national framework for their response to HIV which ensures a coordinated, participatory, transparent and accountable approach, integrating HIV policy and programme responsibilities across all branches of government.

GUIDELINE 2: States should ensure, through political and financial support, that community consultation occurs in all phases of HIV policy design, programme implementation and evaluation and that community organizations are enabled to carry out their activities, including in the field of ethics, law and human rights, effectively.

GUIDELINE 3: States should review and reform public health laws to ensure that they adequately address public health issues raised by HIV, that their provisions applicable to casually transmitted diseases are not inappropriately applied to HIV and that they are consistent with international human rights obligations.

GUIDELINE 4: States should review and reform criminal laws and correctional systems to ensure that they are consistent with international human rights obligations and are not misused in the context of HIV or targeted against vulnerable groups.

GUIDELINE 5: States should enact or strengthen anti-discrimination and other protective laws that protect vulnerable groups, people living with HIV and people with disabilities from discrimination in both the public and private sectors, ensure privacy and confidentiality and ethics in research involving human subjects, emphasize education and conciliation, and provide for speedy and effective administrative and civil remedies.

GUIDELINE 6 (as revised in 2002): States should enact legislation to provide for the regulation of HIV-related goods, services and information, so as to ensure widespread availability of quality prevention measures and services, adequate HIV prevention and care information, and safe

and effective medication at an affordable price. States should also take measures necessary to ensure for all persons, on a sustained and equal basis, the availability and accessibility of quality goods, services and information for HIV prevention, treatment, care and support, including antiretroviral and other safe and effective medicines, diagnostics and related technologies for preventive, curative and palliative care of HIV and related opportunistic infections and conditions. States should take such measures at both the domestic and international levels, with particular attention to vulnerable individuals and populations.

GUIDELINE 7: States should implement and support legal support services that will educate people affected by HIV about their rights, provide free legal services to enforce those rights, develop expertise on HIV-related legal issues and utilize means of protection in addition to the courts, such as offices of ministries of justice, ombudspersons, health complaint units and human rights commissions. International Guidelines on HIV/AIDS and Human Rights 19

GUIDELINE 8: States, in collaboration with and through the community, should promote a supportive and enabling environment for women, children and other vulnerable groups by addressing underlying prejudices and inequalities through community dialogue, specially designed social and health services and support to community groups.

GUIDELINE 9: States should promote the wide and ongoing distribution of creative education, training and media programmes explicitly designed to change attitudes of discrimination and stigmatization associated with HIV to understanding and acceptance.

GUIDELINE 10: States should ensure that Government and the private sector develop codes of conduct regarding HIV issues that translate human rights principles into codes of professional responsibility and practice, with accompanying mechanisms to implement and enforce these codes.

GUIDELINE 11: States should ensure monitoring and enforcement mechanisms to guarantee the protection of HIV-related human rights, including those of people living with HIV, their families and communities.

GUIDELINE 12: States should cooperate through all relevant programmes and agencies of the United Nations system, including UNAIDS, to share knowledge and experience concerning HIV-related human rights issues and should ensure effective mechanisms to protect human rights in the context of HIV at international level.

